

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

**Tribal Advisory Committee (TAC) Meeting**

**August 22 - 23, 2011  
Minutes of the Meeting**

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## Acronyms

ACIP	Advisory Committee on Immunization Practices
AAIHB	Albuquerque Area Indian Health Board
AI/AN	American Indian / Alaska Native
AIP	Arctic Investigations Program
ANMC	Alaska Native Medical Center
ANTHC	Alaska Native Tribal Health Consortium
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
CAMICC	CDC/ATSDR Minority Initiatives Coordinating Committee
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CIOs	Centers, Institutes, and Offices
CMS	Centers for Medicare and Medicaid Services
CRIBH	California Rural Indian Health Board
CSTE	Council of State and Territorial Epidemiologists
DDT	Division of Diabetes Translation
DEOC	Division of Emergency Operations Center
DHAC	Division of Health Assessment and Consultation
DSLRL	Division of State and Local Readiness
EPA	Environmental Protection Agency
FACA	Federal Advisory Committee Act
FMO	Financial Management Office
FOA	Funding Opportunity Announcement
HHS	Health and Human Services
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
ILI	Influenza-Like Illness
IRB	Institutional Review Board
ITCA	Inter Tribal Council of Arizona
JITT	Just-in-Time Training
MASO	Management Analysis and Services Office
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MWPERLC	Mountain West Preparedness and Emergency Response Learning Center
NCAI	National Congress of American Indians
NCEH / ATSDR	National Center for Environmental Health / Agency for Toxic Substances and Disease Registry ATSDR
NARCH	Native American Research Centers for Health
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NDW	National Data Warehouse
NIHB	National Indian Health Board
NPA	National Partnerships for Action
NPAIHB	Northwest Portland Area Indian Health Board

NPHII	National Public Health Improvement Initiative
OCAITHB	Oklahoma City Area Inter-Tribal Health Board
OGC	Office of General Counsel
OMHD	Office of Minority Health and Health Disparities
OMHHE	Office of Minority Health and Health Equity
ONDCP	White House Office of National Drug Control Policy
OPHPR	Office of Public Health Preparedness and Response
OPPE	Office of Policy, Planning, and Evaluation
OTA	Office of Tribal Affairs
PHAB	Public Health Accreditation Board
PHAP	Public Health Associate Program
PHEP	Public Health Emergency Preparedness
PIM	Performance Improvement Manager
PPACA	Patient Protection Affordable Care Act
PREP	Personal Responsibility Education Program
PSA	Public Service Announcement
RFP	Request for Proposal
RPMS	Resource and Patient Management System
RWJ	Robert Wood Johnson
SAMHSA	Substance Abuse and Mental Health Services Administration
SEARHC	South East Alaska Regional Healthcare Consortium
SNP	Strategic National Stockpile
SOPs	Standard Operating Procedures
STAC	Secretary's Tribal Advisory Committee (HHS)
STIs	Sexually transmitted infections
TAC	Tribal Advisory Committee
TCAC	Tribal Consultation Advisory Committee
USET	United and South Eastern Tribes
WHO	World Health Organization
WIC	Women, Infants, and Children

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

**Minutes of the Meeting  
August 22-23, 2011**

## **Opening Blessing / Welcome / Introductions**

**Chester Antone, TAC Co-Chair  
Councilman, Tohono O'odham Nation**

**Brenda Nielson, TAC Portland Area Host  
Executive Secretary NPAIHB Quileute Tribe**

**Gregory Holzman, MD, MPH  
Associate Deputy Director  
Office for State, Tribal, Local and Territorial Support (OSTLTS)  
Centers for Disease Control and Prevention**

Chester Antone, TAC Co-Chair, called the meeting to order and welcomed everyone. As is the custom in Indian Country, he requested that Mr. Secatero honor them with a blessing to begin the morning. Following the blessing, the roll call confirmed that there was a quorum (N=9) and that the meeting could proceed. The participant roster is included in the appendices of this report. Mr. Antone indicated that he has been serving on the Tribal Advisory Committee (TAC) for the Centers for Disease Control and Prevention (CDC) for four years, since he was first elected to the O'odham Legislative Council. He explained that the purpose of the TAC is to move forward on more solid ground. The reorganization of CDC left the Tribal Consultation Advisory Committee (TCAC), the original iteration of this CDC advisory committee, in a state of limbo. He emphasized the importance of the CDC TAC, particularly with the Earth changing and the problems in Indian Country that require assistance. Many of the tasks within the Patient Protection Affordable Care Act (PPACA) fall within the purview and responsibility of CDC, and tribal representatives must chime in on some of those issues.

Brenda Nielson, Quileute Tribe member, Northwest Portland Area Indian Health Board (NPAIHB) and host for the Portland area, welcomed everyone to the beautiful Pacific Northwest. She noted that those who arrived early the evening before were entertained in the courtyard by the Quileute Drum Group, which was on the way to a totem pole raising ceremony, and that she had invited the group to play for them that morning. She said that NPAIHB was looking forward to hosting the meeting, as well as the tour to Neah Bay the next day. The Makah Tribe has been very gracious about having the group tour their village, and planned to serve a traditional salmon dinner with some traditional dancing and drumming. Following the dinner, the group would take a tour through the amazing and beautiful museum in Neah Bay, followed by which they would return to the community center for a tribal meeting with the Makah Tribe elders and tribal council. She expressed her hope that they would have a great meeting and field trip.

Dr. Greg Holzman indicated that he was new to CDC, having been there just three months. Prior to joining CDC, he was the Chief Medical Executive for the Michigan Department of

Community Health, Associate Professor in the Department of Family Medicine at Michigan State University, and Adjunct Associate Professor in Health Management and Policy at the University of Michigan's School of Public Health. He also worked with the Indian Health Service (IHS). Before completing his second residency in preventive medicine, he worked on the Blackfeet Indian Reservation in Browning, Montana, as well as a month in Kotzebue, Alaska during his training. He expressed his hope that they could continue to be bold and move the agenda forward, and stressed the importance of speaking openly and honestly. While he said he is not Native American, he is culturally sensitive. He hoped everything he said would be appropriate, but emphasized that if something he said could be construed the wrong way, he wanted everyone to feel free to tell him. He emphasized that his heart and interests were in the right place. When he was working on the Blackfeet Indian Reservation, he was inspired to complete a second residency in preventative medicine and obtain his Master's Degree in Public Health, given that he observed public health playing a part in the health issues. He lost good friends due to motor vehicle accidents, and there is no reason for there to be a 250% higher death rate in motor vehicle accidents among the Native American population than in the Caucasian population in the United States. Dr. Holzman thanked everyone for inviting him to attend, and stressed again that they should speak openly and honestly to make Indian country the healthiest they possibly could.

Mr. Antone indicated that they would conduct the TAC Business meeting at this point, in which only the TAC members and delegates would be involved. He excused everyone else until the first break.

## **TAC Business Meeting**

### **Election of Chairman**

#### **Chester Antone, TAC Co-Chair Councilman, Tohono O'odham Nation**

Mr. Antone indicated that the first order of business was to hold elections for the Chair and Co-Chair positions. He has served in the capacity of Co-Chair with Kathy Hughes since Jefferson Keel left for the National Congress of American Indians (NCAI), although he still continues to be a member. Given that Ms. Hughes is unfortunately no longer serving in the capacity of tribal elected official, she had to step down from her TAC role. He expressed his gratitude for all of her work while serving on the TAC, and noted that he had heard great things about her involvement with CDC staff members. He has also had great respect for many years for Ms. Hughes in her role as Vice Chairperson at Oneida in Wisconsin. Mr. Antone noted that while Ms. Hughes will be missed in her roles at Oneida and on the TAC, he expected that, as with all great tribal leaders, her voice would continue to be heard in some capacity. He then opened the floor for nominations for two Co-Chairs.

Ms. Cantrell read through the current appointment process to refresh everyone's memory, which states that "The Co-Chair will be elected by and from among the TAC members for a one calendar-year term of service. The Co-Chair will be an elected tribal leader. The number of terms is not limited." In terms of re-election, the charter states that "The Chair and Co-Chair may be reelected by the TAC."

**Motion**

Mr. Petherick nominated Chester Antone and Brenda Nielson to serve as TAC Co-Chairs. The nomination was seconded. A vote was taken by roll call, and the nomination was affirmed. The motion carried with 11 affirmative votes, 0 negative votes, and 0 abstentions.

**Approval of February Minutes****Chester Antone, TAC Co-Chair  
Councilman, Tohono O'odham Nation**

Mr. Antone indicated that the next order of business was approval of the February 2011 TAC minutes. Members were directed to the 4<sup>th</sup> tab in their notebooks, which contained a copy of these minutes.

**Motion**

Ms. Reft moved to approve the February 2011 minutes. Mr. Petherick seconded the motion. A vote was taken by roll call, and the motion carried with 11 affirmative votes, 0 negative votes, and 0 abstentions.

**Three to Five Issues to Raise to the Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC)****Chester Antone, TAC Co-Chair  
Councilman, Tohono O'odham Nation**

Mr. Antone opened the floor for a discussion regarding issues that could be raised to the Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC). He explained that the STAC is a Cabinet level committee, so it is essential to submit important TAC issues to that committee. The following points were made, which Ms. Cantrell indicated she would write up and distribute to TAC members for approval:

- Collaboration and coordination between federal agencies, and between states / locals and tribes will help to maximize the benefits from all of the programs that could help tribes:
  - Tribes should have direct access to funding for public health activities, and when state / local governments receive funding, requirements should be placed upon them to conduct meaningful work in Indian Country. State / tribal relations must be enforced, and CDC's support is needed for this.

- Dr. Monroe's suggestion to have a meeting with IHS, Centers for Medicare and Medicaid (CMS), and CDC regarding the impact of Medicaid within the State of Arizona shows that these agencies are starting to move together. This was not true previously, with everyone maintaining their territory and jurisdiction.
- Many of CDC's activities are conducted through direct cooperative agreements or grants to state and local health departments rather than directly to tribes.
- The reporting required for cooperative agreements is very cumbersome, which is a hindrance for tribes that do not have the manpower to meet the requirements. This is likely a barrier for tribes in terms of competing for funding. The yearly report can be hundreds of pages and is highly repetitive. Simplification of reporting requirements could result in more inclusiveness in terms of all tribes being able to compete for cooperative agreement funds.
- During the TCAC meeting 4 years ago, there was discussion regarding states' usage of tribal numbers to obtain funds from CDC; however, very little of those funds are actually allocated to the tribes within the areas receiving the funds. After much discussion, it was suggested that a guidance document be developed that would require states to seek permission from tribes or include tribes in their CDC grant applications to CDC, and for states to be required to describe how are they providing services to tribes within their areas. An update about this guidance document should be an agenda item for the February 2012 TAC meeting.
- Oklahoma's state health department receives funding from CDC, but it is difficult for tribes to access those programs (e.g., emergency management funding). CDC's cooperative agreement language typically requires state / local health departments to work with tribes to ensure that tribes are able to access those resources; however, this is not always an easy process.
- The California Department of Alcohol and Drug Programs recently approached the California Rural Indian Health Board (CRIHB) requesting a consultation regarding how to devise consultation processes in California, given that the state department is going to be eliminated and their funding will be allocated to county governments. There are 110 tribes in California, most of which do not have relationships with county governments. Dissemination of funding at the county / local level with no consultation processes could result in these tribes not having input into allocation of these funds. Ultimately, those funds are allocated from federal sources, and there is little infrastructure to ensure that tribal consultation is achieved.
- The Navajo Nation is currently in a position to execute a lot of programs themselves, for example, The Navajo Birth Cohort Study. This study focuses on the impact of uranium. The ultimate goal is to conduct longer term studies, for which adequate funding is needed. It seems as though there are usually short-term studies and then funding runs out. Sufficient funding should be provided from the outset in order to secure sustainability of activities that result in adequate health care for Indian Country.



- Access to data continues to be a major issue:
  - The Nashville Area is fortunate to have direct access into the Tribal Resource and Patient Management System (RPMS); however, this is not the case for all areas.
  - Obtaining CDC data requires a lengthy process, which needs to be made smoother and easier to deal with.
  - The Indian Health Care Improvement Act (IHCIA) includes a provision that grants Tribal Epidemiology Centers access to all HHS data, but this provision must be clarified to bring this access to fruition. The problem seems to lie with the interpretation of the provision in terms of whether access is intended to be to all HHS data, IHS data only, and / or cleaned / de-identified National Data Warehouse (NDW) data. The problem with NDW data is that these do not allow for comparisons beyond the general American Indian / Alaska Native (AI / AN) population. Area-to-area cannot be compared.
  - Tribes need to know how to make agreements with CDC regarding data access, and what CDC will accept in terms of data gathered by tribes from within tribes. CDC will probably consider data from HIS and states as credible sources, but it is unclear whether data from within tribes will be accepted. Tribes need assistance collecting data and analyzing what has already been collected to make it credible to CDC.
- The TAC remains in limbo due to the reorganization of CDC:
  - It is hoped that filling the Associate Director position will help to address this issue. The positions under the Associate Director must be filled as well, so that the focus can be turned to moving forward.
  - CDC needs to review the issues raised by TCAC in the past, and help to move those issues forward. The issues have been raised repeatedly, but there seems to be no movement on them.
  - Sustainability of staff within OSTLTS is imperative to continue to work with tribes to resolve issues.

#### **Motion**

Mr. Jim moved to accept the issues raised as those that would be fleshed out by Ms. Cantrell, returned to TAC members for approval, and submitted to the STAC. Ms. Reft seconded the motion. A vote was taken by roll call, and the motion carried with 11 affirmative votes, 0 negative votes, and 0 abstentions.

#### **Discussion of Subcommittees**

**Chester Antone, TAC Co-Chair**

## **Councilman, Tohono O'odham Nation**

Mr. Antone reported that about three years ago, TCAC stood up the three subcommittees, two of which were the Budget Subcommittee and the Public Health Preparedness and Response Subcommittee. While the subcommittees started out with a lot of energy, over time they fizzled out due to other pressing issues. He thought it was time to revisit the issue of subcommittees in order to address some complex issues, such as the budget and how it pertains to tribes in terms of measuring progress over the years, whether the budget has increased, and what funding has done for tribes. Consulting with CDC typically focuses on the larger issues, but does not address the details. Perhaps establishing subcommittees will help to impact the larger issues that are raised. The federal government is currently working on the budget three years out, so TAC must determine what their wishes are for the third year and needs to know what has been proposed for the second year. This is particularly critical now, given that the total federal budget is supposed to be reduced by \$1 trillion. This is another reason that it is imperative to fill the Associate Director position and the position's support staff as soon as possible.

During this session, a Budget Subcommittee was established. The potential tasks for this subcommittee are to address budget needs for CDC; assess how CDC's funds are apportioned internally; and drill further down to better understand how internal CDC dollars are allocated to tribal issues. It was noted that membership was open to primary and alternate members. Volunteering to serve on this committee were Chester Antone, Joe Finkbonner, Rex Lee Jim, JT Petherick, and Dee Sabattus. Reno Franklin was suggested as a member and will be contacted for confirmation regarding whether he would like to participate or appoint an alternate to participate on his behalf. It was suggested that Michael Franklin from CDC's Financial Management Office (FMO) be included, and that other technical advisors be included as needed.

### **Motion**

Mr. Petherick moved to establish a TAC Budget Subcommittee with the membership to be comprised of: Chester Antone, Joe Finkbonner, Rex Lee Jim, JT Petherick, and Dee Sabattus. Ms. Nielson seconded the motion. A vote was taken by roll call, and the motion carried with 11 affirmative votes, 0 negative votes, and 0 abstentions.

Establishment of a Public Health Preparedness Subcommittee was deliberated, and the group agreed that this should be revisited at a later time. Consideration was also given to the establishment of a Public Health Accreditation Subcommittee that would potentially address issues related to tribal capacity to apply for accreditation; assess how CDC can work with tribes to assist them in building their capacity to enable them to apply for accreditation; and to bridge the gap between the committee that was working to set standards and the TAC Public Health Accreditation Subcommittee. Rather than establishing a subcommittee at this time, it was suggested that perhaps a member of TAC could be appointed to serve as a Technical Advisor. Given that his site was a beta test site, JT Petherick indicated an interest in serving as the Health Care Accreditation Technical Advisor.

### **Motion**

Ms. Nielson made a motion to nominate JT Petherick to serve as the Health Care Accreditation Technical Advisor. Ms. Reft seconded the motion. A vote was taken by roll call, and the motion carried with 11 affirmative votes, 0 negative votes, and 0 abstentions.

### **Discussion Points Related to These Motions**

- Mr. Antone indicated that Mr. Franklin participated in the previous Budget Subcommittee efforts, and provided some documentation that the subcommittee requested. He expressed concern that TCAC asked for a tribal set aside once, and Mr. Franklin stated that he wanted to treat everybody equally. However, this opinion does not take into consideration the government-to-government relationship that defines CDC's relationship with tribes.
- Ms. Kaslow mentioned that she sat on the Advisory Committee for Public Health Accreditation. Two were informing that initiative. The National Indian Health Board (NIHB) was given the task of working with CDC to develop not only the standards with the Public Health Accreditation Board (PHAB), but also to have an advisory committee assessing ancillary issues related to that initiative. They last met about three months ago in Alaska, and a great deal of concern was expressed about having a voice with CDC to channel some of the concerns that were being articulated by some of the members who attended that meeting. Stacy Bohlen is an active partner in the initiative.
- Mr. Antone noted that NIHB is playing that role with Association of State and Territorial Health Officials (ASTHO) and has a cooperative agreement with them. He wondered whether TAC needed to chime in on that as an advisory committee to CDC.
- Ms. Cantrell clarified that if CDC has a cooperative agreement with a specific organization and they happen to sit as a member on the committee, that potentially is a conflict of interest in terms of serving in the role of an advisor. CDC's TAC, with members in 12 regions, also has the opportunity include members from national organizations on its own subcommittee.
- Mr. Petherick thought it was important to include a tribal nation that has direct contact with CDC, given that they are the ones that will be applying for accreditation.
- Ms. Cantrell noted that Mr. Greg Smith would be speaking later about preparedness. He has been appointed by OSTLTS as the Tribal Liaison for Preparedness. It may be beneficial to him and TAC to appoint a Technical Advisor to him from the TAC.

At this point, the business meeting was adjourned. Upon reconvening the full group, Mr. Antone announced that he and Ms. Nielson were elected as the TAC Co-Chairs.

## **Office for State, Tribal, Local and Territorial Support, CDC**

**Gregory Holzman, MD, PhD**

**Associate Deputy Director  
Office for State, Tribal, Local and Territorial Support  
Centers for Disease Control and Prevention**

Dr. Holzman offered a brief update of some of the activities underway within the OSTLTS office. One of the most important efforts is hiring a Tribal Director. He expressed gratitude to Dr. Duckworth for her work as Acting Tribal Director for the last year and a half, and indicated that she would soon be moving on. He plans to keep Dr. Duckworth on board for a while to ensure a smooth transition. Over 140 applications were received for this position. These have been reviewed, and interviews were expected to begin the week following the TAC meeting. Mr. Antone will serve on the committee to help them select a few individuals who will be interviewed. They expected to make an offer by sometime in September, although the individual who accepts the role may have to give notice in a current job, so he or she may not actually begin the job until late fall or early winter. The goal is to have someone in place as soon as possible. Although there is currently a hiring freeze at CDC, it will not affect the hiring of this individual or the two positions under this one.

OSTLTS will publish a Funding Opportunity Announcement (FOA) in March 2012 for the one-year umbrella project to be conducted by some of the national AI / AN organizations. The National Public Health Improvement Initiative (NPHII) grants are also administered by the OSTLTS office. All 8 tribes that have been funded through this initiative received Component 1, while 1 tribe received Components 1 and 2. He requested that Dr. Duckworth speak further about these two initiatives. Dr. Duckworth added that in terms of the FOA, initially two cooperative agreements were awarded through OSTLTS to NIHB and NPAIHB. The new FOA will be open to tribal organizations. In the interim, OSTLTS has continued to fund NIHB and NPAIHB through a sub-agreement with ASTHO. The activities currently done by those two organizations will continue through a sub-agreement. OSTLTS will keep the TAC posted with regard to progress on publication of the announcement, which will be posted on the OSTLTS website once it is available for tribal organizations to actually apply for it. Information is included on the website with regard to the NPHII grants in terms of the activities being undertaken by the 8 tribal organizations. There has been a significant amount of progress. Most of the organizations have identified a Performance Improvement Manager, and are working toward the goals they have identified. Many are at the point of receiving their continuation funding, which is currently being reviewed. She noted that representatives were present from three of the organizations receiving these funds (e.g., Navajo Nation, Cherokee Nation, and NPAIHB) should anyone wish to speak with them directly about their activities.

Given that he was coming into the middle of all of this work, Dr. Holzman indicated that he has been reading through some of the paperwork from the meeting last February regarding working on state and tribal relations. He heard that it was a very productive meeting, and that one of the conclusions was that there needed to be further discussion about trying to bring in more federal partners from CMS, IHS, and CDC. OSTLTS continues to try to move forward to work with its partners at the federal level. While the logistics have not yet been determined, OSTLTS would like to convene a second meeting that coincides with the winter TAC meeting. People will be traveling in already, so hopefully a quorum will be present. State / tribal relations is an area that OSTLTS will work continually to improve, and they would like the TAC to continue to help them do that and shine the light on excellence.

Dr. Holzman noted that there is a program within OSTLTS called the Public Health Associate Program (PHAP), which is an on-the-job training program for Public Health Advisors and Public Health Analysts. PHAP has been very successful in its short tenure. One of last year's major

goals was to try to place individuals within tribal organizations for their two years of training. The hope is that this will entice as many of these individuals as possible to continue to work in the field. With strong recruitment efforts, three associates were placed within tribal organizations this year. There is still room for improvement, but this program is moving in the right direction and OSTLTS is very happy about that.

As everyone is aware, the US economy continues to experience difficulties. The national budget is looking very tight, although the specifics are not yet known. With potential cuts, Dr. Holzman emphasized the importance of being specific about objectives, "asks," and anticipated outcomes to show success moving forward. They must be very straightforward and show, in very simplistic terms, the importance of improving the community health of Native Americans and Alaska Natives. The disparities are vast and there is no reason for this. These gaps must be closed, and they must partner the best they can to continue to address these issues boldly and straight on.

## **CDC Tribal Consultation Policy**

**Chester Antone, TAC Co-Chair  
Councilman, Tohono O'odham Nation**

**Kimberly Cantrell  
Public Health Advisor, Tribal Support Office  
Office for State, Tribal, Local and Territorial Support  
Centers for Disease Control and Prevention**

Mr. Antone indicated that during the discussion the revision of the Tribal Consultation Policy and the TAC Charter, comments would be welcomed from the membership only at this time, given that both are still under revision and are still internal to CDC. Having just received the latest draft of the Tribal Consultation Policy on Friday, he did not believe they could do the document justice during this meeting. Nevertheless, he indicated that Ms. Cantrell would review some of the recommended changes. He discussed this document with Ms. Sabattus, who served on the federal workgroup committee for the HHS Tribal Consultation Policy that is over all HHS agencies. At some point in the future, a TAC conference call can be convened to discuss how TAC might contribute to that effort. He requested that Ms. Sabattus take the lead to provide comments on the CDC Tribal Consultation effort, as she played a major role in the HHS Tribal Consultation Policy. She indicated that she would support TAC in this effort.

Given the number of new members, Ms. Cantrell first brought everyone up to date regarding what has transpired in the last six months with regard to the CDC Tribal Consultation Policy, as well as the next steps. Following the last TAC meeting, a draft was created internally that was circulated to all of CDC's centers for review and response. That first draft incorporated a lot of the language from the HHS policy. It is important to remember that CDC is a sub-agency under HHS, so being repetitive in terms of including the HHS policy in the CDC policy is not necessary. The HHS policy is the umbrella policy, and CDC has the ability to either adopt the HHS policy as is, which some HHS agencies are doing, or to develop a specific CDC / ATSDR policy. Ms. Cantrell clarified that she often refers to just CDC versus CDC / ATSDR, and explained that although administratively CDC has moved the Office of the Director for ATSDR within the National Center for Environmental Health, ATSDR is still recognized as its own

agency within HHS. Given the environmental issues in Indian Country, it is important that the Tribal Consultation Policy recognizes that ATSDR has a responsibility as well.

In terms of developing a CDC Tribal Consultation Policy, the policy that was in place expired in October 2010. At that time, the HHS policy had not been adopted, so CDC did not want to begin a process that might have conflicted with the HHS policy. That was part of the reason for the delay in instituting a new CDC Tribal Consultation Policy. Once the first draft was written and the centers reviewed it, their comments were incorporated. The draft being presented during this session was the iteration following those revisions. They also met with the CDC group responsible for policy development to ensure that the document was being developed appropriately, and basically followed a standard template CDC uses for developing policies.

The next draft will include not only the input incorporated from the centers, but also the input from the TAC members. Once the centers agree to that draft, it will go through the formal process for developing policy at CDC. Though the current process is still informal, once the policy is submitted to the Management Analysis and Services Office (MASO), MASO will submit it to a board, which meets once per month, and will decide whether to put the policy into effect. OSTLTS has applied to be included on the agenda. The board was brought into the process early, and is aware that instituting the policy is a top priority. The board is ready to work with OSTLTS to move forward. Subsequently, the Office of General Counsel (OGC) will review the policy, it will be published in the *Federal Registry* to solicit comments. Once the comment period is over, those comments will be incorporated into the final draft. At that point, the centers will review the policy, and CDC will motion to make it a final policy. Once the policy is in place, OSTLTS will “do some road shows” throughout the various CDC centers to ensure that they are aware that there is a Tribal Consultation Policy, and to explain their responsibilities in terms of the government-to-government relationship. This is not merely about publishing a policy—they must make sure that it is integrated into how CDC does business. Having a TAC Budget Subcommittee in place will help ensure that CDC recognizes tribes as they should.

Once the policy is in place, OSTLTS will also follow internal Standard Operating Procedures (SOPs), which guide how OSTLTS will reach out to the centers to assist them with the process. This includes a reporting mechanism to help OSTLTS assess what types of consultations are occurring at CDC, which will be reported to the TAC. While consultation may be occurring, they do not necessarily know how often and with whom. OSTLTS will serve as the gatekeeper to ensure that the policy is being properly supported by the centers.

In terms of the changes to the policy, Ms. Cantrell referred participants to the copies in their binders of the policy as revised on 8/16/11, the current policy that was put in place on 10/18/05, and the HHS Tribal Consultation Policy. She emphasized that it would not be possible to review the documents and make thoughtful comments in 45 minutes, but she wanted to quickly review some of the changes and give everyone the opportunity to make any comments that came to mind as they went through this process. OSTLTS wanted to make sure that people understood the importance of the *Waiver*, so this was placed in the front of the document. The next item is the *Purpose*, which was expanded upon to ensure that it was clear that both CDC and ATSDR would be held accountable. The abbreviations and acronyms were moved to the back of the document, and were expanded somewhat. OSTLTS is now the body that is responsible for this policy. Previously, this was the responsibility of CDC’s Office of Minority Health and Health Disparities (OMHD). The next section, *Philosophy*, was changed somewhat. The term *American Indian / Alaskan Native Tribes* was changed to *Indian Tribes*. The HHS policy did not specifically address state tribes, but the CDC policy does include a comment about addressing

state tribes. The *Introduction* was changed somewhat, with the same expansion to ensure that it was clear that both CDC and ATSDR would be held accountable.

The *Background* section contains three important points: tribal sovereignty, the government-to-government relationship, and federal trust responsibilities. One of the challenges in talking to people who are not aware of the policy is that they do not understand the relationship the agency should have with tribes, so it is very much an educational process. Speaking to these issues within the policy makes it more readable for the general population, as well as the CDC / ATSDR staff who have to follow the policy. The next section is the actual *Policy*. The first sentence speaks to the HHS policy being the overarching policy to which CDC / ATSDR will adhere. Changes were made to the next section, *Responsibilities*, in terms of who the owner of the policy is and who is responsible for ensuring adherence to the policy. This is where the change was made from OMHD to OSTLTS. This is the section that includes information about the missions of OSTLTS and ATSDR. It also further outlines the responsibilities of OSTLTS and ATSDR. This is followed by the *Procedures* section. A significant amount of time was spent on this section in order to ensure that it is understandable and could be adhered to. The *CDC/ATSDR Consultation Protocol* document offers a visual of the procedures to help make them easier to understand. Also included in this section are the definitions of an *Action* or *Critical Event* and *Consultation*. This section also addresses who can decide Tribal Consultation is an appropriate course of action, guidelines for initiating a consultation, components to ensure effective consultation, who should participate, engaging tribal leaders, documentation and accountability, provision of feedback, schedule for consultation, evaluation of the consultation process, and additional consultation forums. The section regarding additional consultation forums defines the TAC and its purpose, and discusses the CDC Biannual Tribal Consultation Sessions. There is also discussion about CDC's responsibility to participate in the HHS National Budget and Policy Consultation Session, Regional Consultation Sessions, and consultations with the state health departments. This section is followed by acronyms and additional resources. Some of these resources were in the original policy, so there needs to be some discussion regarding whether they are still appropriate.

### **Discussion Points**

- Ms. Sabattus requested clarity regarding whether Ms. Cantrell was saying that TAC members would not have an opportunity to comment on the document until it is published in the *Federal Registry*.
- Ms. Cantrell responded that TAC is commenting now. Following the last TAC meeting, there were some issues surrounding the discussion of the policy. The decision was made during the last meeting not to go through line by line striking things out. CDC had an issue on its side, and some conflicting differences. Those were corrected and they moved forward to develop a policy to which TAC members could react.
- Ms. Allison wondered whether it would be beneficial to go through a brief crosswalk between the original and the latest draft.
- Regarding the potential of redundancy between the HHS and CDC policies, Ms. Sabattus expressed concern that someone coming in new at CDC may review only the CDC policy and consider it to be their orders, without knowing about the HHS provisions unless something was said about this up front.

- Ms. Allison said she thought within the current revised version, reference is made to the HHS policy and there is an explanation stating that the CDC policy is intended to complement the HHS policy. Based on the internal comments received from their CDC and ATSDR colleagues, it was striking to learn that few people knew there was a tribal consultation policy in place. The only thing they heard about the original CDC / ATSDR policy was that it was very general. While she thought the original policy was good, she agreed that it was very general. People were interested in understanding what constitutes formal consultation with tribes, and the steps that must be taken in order to honor and respect that process. In developing the draft, they really wanted to convey three important ideas: 1) the trust responsibility that the federal government has with federally recognized tribes, 2) the meaning of tribal sovereignty in terms of self-governance / self-determination, and 3) how this occurs through the government-to-government relationship. Given that this policy is reviewed and used internally and is also reviewed by tribal communities, they wanted to include an introductory component to explain the missions of CDC and ATSDR, discuss why this policy is important, and emphasize CDC's and ATSDR's commitment to honoring this policy. There was also a goal to keep the policy simple and not make it too repetitive, which Miss Allison felt they had accomplished. They also clarified some roles within CDC and ATSDR in terms of who to contact with questions about the consultation process and / or about implementing the process effectively. She heard from a number of people that formal consultation can be intimidating, especially if they are unsure of the process itself. The agencies also recognize that there are several forms of consultation. There is outreach, or working diligently to inform tribes about CDC's and ATSDR's roles and responsibilities, the FOAs for which tribes may be eligible. There is more formal consultation in terms of notifying tribes about a critical event or an action that might affect their communities, land, and resources. Then there is formal consultation itself, which is the Consultation Meeting during which tribal leaders meet with CDC / ATSDR leadership to discuss an event that might impact them directly. An explanation of those forms of consultation is also provided in the policy document. She emphasized that this draft was developed as a result of input from internal CDC / ATSDR colleagues and in discussions with some tribes about how they viewed consultation.
- Ms. Cantrell added that she felt the old policy was hard to follow. Given that, and the fact that so many CDC / ATSDR staff were not even aware of the policy, it was evident that they needed to do a better job of explaining the policy so that they could clearly hold people accountable to it.
- To offer an example, Ms. Allison noted that NCEH, a component of CDC and ATSDR, receives calls from tribes who want a hazardous waste site investigated. They often will request a formal consultation to discuss such an issue. Ms. Allison has to inform leadership about what the tribe is requesting and let them know that they must honor the request. If the tribe is amenable to a conference call, this will be arranged to start the discussions. This might be followed by a formal in-person consultation. It is important to have a process in place that supports the consultation policy.
- Ms. Allison emphasized the importance of stipulating who they would be engaging with, why they would be engaging, and the process for engaging. Some of the comments received regarded the fact that there is often a misconception that IHS is the entity that is responsible for all tribal affairs. They wanted to be clear in the policy that all federal agencies have a trust responsibility to work with tribes, and wanted to further define this concept and connect it to why CDC and ATSDR needed to honor this policy. She requested comments on the



*Procedures* section in terms of whether it appears to be on the right track. While she thought what was written was a good start, she felt that it could definitely be finessed more.

- Mr. Antone requested clarification about TAC versus TCAC, and whether the TAC was meant to serve as an overall advisory group to CDC / ATSDR.
- Ms. Cantrell reminded everyone that during the February 2011 meeting, a formal vote was taken to change the name from TCAC to TAC. The discussion surrounding that was that the old name was very limiting in terms of what the group could be involved in. The word *Consultation* was removed. There was also discussion about aligning with the Secretary of HHS in terms of having an overall advisory committee versus just formal consultation.
- Regarding the flow chart, Mr. Antone requested clarification about initiating the consultation process.
- Ms. Allison replied that a request could progress into formal consultation. The bottom of the flow chart page includes the definition of an action or a critical event, and a lot of the bulleted items came from the original policy. A few more were added, but she invited suggestions or recommendations for any that were missing.
- Given that the members had received the draft just before the meeting, Mr. Antone suggested having a conference call at a later date when everyone had the opportunity to review it thoroughly.
- Ms. Cantrell proposed that everyone take two weeks to review the policy and develop comments. She, Ms. Allison, and Ms. Sebattus will then review the comments, incorporate them as appropriate, and return the next draft to the members for review. Once they reach a good working place, they can have a telephone call to approve the version in which the TAC members' comments are incorporated. She suggested that the members submit their comments by September 2, 2011.
- Mr. Antone requested a due date after Labor Day, perhaps September 9<sup>th</sup>.
- Ms. Cantrell cautioned that the longer they take, the longer it will take to get the draft through the process internally. She thought they should hold off returning the draft to the centers until the TAC members' comments were incorporated. If they could get agreement from the centers and incorporate their comments, they could complete what would be the third draft for TAC members. She would like to submit the document to MASO no later than the third week of October.
- Ms. Allison felt that September 9<sup>th</sup> was cutting it too close, and she suggested September 16<sup>th</sup>. She pointed out that if they were going to submit the next draft to the centers and incorporate their additional comments, they would need at least 30 days to do that too. That process would have to be completed by October 14<sup>th</sup>. To give the centers time to obtain internal buy-in, she would feel more comfortable submitting the policy to MASO in November. She also indicated that she recently established an initiative to conduct a National Tribal Environmental Health Think Tank, which is a group of tribal professionals from across the country who are working with her to determine priorities and ultimately develop a strategic plan for her office. She requested permission from the TAC members to permit this group to review the Consultation Policy to obtain additional input.

- Mr. Antone responded that he thought this would be fine in order to acquire some additional comments.
- Mr. Jim referred everyone to the first page and second paragraph of the draft that states, "True and effective consultation shall result in information exchange, mutual understanding, and informed decision-making on behalf of the tribal governments." He asked who would be making the decision and what language in this policy guarantees that what he and other tribal leaders say will be integrated into and become part of that decision-making. He was unable to find any such language in the current draft, including on page 6 where the meaning of *Consultation* is defined.
- Ms. Allison responded that they need to correct the language to address this issue, which has been raised previously. Ultimately, it is the tribes' decision. While the deliberation process should result in mutual understanding gained by both parties, the tribe has the option to make whatever decisions that are important for their communities.

## Revision of the TAC Charter

**Kimberly Cantrell**  
**Public Health Advisor, Tribal Support Office**  
**Office for State, Tribal, Local and Territorial Support**  
**Centers for Disease Control and Prevention**

Ms. Cantrell reminded everyone that during the February 2011 meeting, they attempted to review a TCAC Charter document that had previously been marked up. However, it was unclear who made the revisions in that particular version. Therefore, the decision was made to review the HHS Charter compared to revisions being made internally within CDC. As with the Tribal Consultation Policy, OSTLTS now oversees the TAC Charter rather than OMHD. Therefore, OMHD was changed to OSTLTS throughout the charter. All the references to TCAC were changed to TAC in accordance with the vote during the February 2011 meeting to change the name. The *Purpose* and *Authority* did not change. The *Function* section addresses the Federal Advisory Committee Act (FACA) exemption. The charter also addresses structure, support, the appointment process, leadership, period of service, meetings, voting, quorum, and compensation. Ms. Cantrell said she thought they needed to review the functions to ensure that they are appropriate. Regarding the inclusion of national organizations, HHS is restructuring Direct Service Tribes and Tribal Self-Governance, which are included as members of the committee in the TAC Charter.

Regarding support, the section that was removed from the original policy was specific to NIHB support. It discussed supporting the TAC through a contract to provide for meetings and other TAC functions. Meeting support is being provided in a separate contract, which is not with NIHB, so that was removed. Given the vote to add a TAC Budget Subcommittee, and the potential to add new subcommittees in the future, the structure will be an important component. To be more effective, it is important to move from strictly information exchange to actually working on issues.

### Discussion Points

- Regarding Direct Service Tribes and Tribal Self-Governance, Mr. Antone noted that these are included in most charters for advisory committees. Some of the discussion about this regarding the fact that many charters include Washington-based organizations, which he thought had since been revised under the overall HHS Tribal Consultation Policy to include at-large members so that other organizations can be involved. Since his initial involvement, NCAI and NIHB were listed; however, that has since changed. He suggested adding the language “included, but not limited to.”
- Ms. Cantrell replied that this goes in the Structure section, which defines which groups are to be included.
- Mr. Antone noted that in the past, there have been issues with getting some areas to participate. Part of the problem is that there has always been a requirement for tribal leaders to participate, but participation is time-consuming. He suggested making a change to the charter that specifies that those who are attending on behalf of a tribal leader or those who are designated persons from certain tribes or certain areas must have the authority to act on behalf of the tribe. Incorporation of this language could ensure full participation. The HHS policy states that the Tribal Vice Chairman should be the member and then the elected official should be a designee. The designee should be able to act on behalf of the tribe or tribes in that area. He also suggested that the term limit should be changed from one to two years to provide continuity.
- Ms. Cantrell indicated that the term limits were removed from the latest version, and it states that the Chairman will be an elected tribal leader. She asked Mr. Antone to further clarify his idea about terms and elections.
- Mr. Antone thought that it would be fine to hold yearly elections, but that a two-year election process would also be fine. He just did not want to limit someone to serving only two terms. He also recommended that they designate an official place of record. There seems to have been a lack of recordkeeping in the past. Not only is this important for history, but it may also become important if there is ever litigation. Not having records, especially about membership and alternates, could result in work done by the membership being invalidated.
- Ms. Cantrell responded that a file was passed down CAPT Snesrud. They have asked for letters for alternates who were not members, and the letters are kept in a file. The Communications Office suggested creating a SharePoint website that would be password restricted where documents could be archived that would not be widely distributed on the internet, but to which members could have access. If the group thought this would be useful, she said she would explore it further. This would also provide a forum for documents that need to be commented upon. This would reduce email traffic and result in more organization. Mr. Antone and others agreed that further exploration of this would be a good idea.
- Mr. Jim wondered why, under *Structure*, language was included that states, “In addition, the TAC will include one representative (and designate alternatives)” and then lists only NCAI, TSGAC, and DSTAC. He would like there to be a member from the National Indian Education Association (NIEA). Education is very important and the TAC should include a voice on education. It would also be nice to have someone from NCAI and other organizations. There are other organizations for large land-based tribes for which the membership may be small, but they represent the majority of the Indian people in an area. In terms of the suggestion to add language about those sitting at the table having decision-

making authority, some may represent only their tribe and may have to consult with other tribal groups from their area.

- Ms. Sabattus objected to including NIEA, given that this is an individual type of organization rather than representation from an Indian tribe. NIEA has individual Indian members who cannot act in the capacity of an Indian tribe.
- Ms. Cantrell requested further discussion regarding the number of meetings and teleconferences. When TCAC was initially stood up, there were quarterly meetings. That was later reduced to biannual meetings, one of which is convened in Atlanta and the other of which is convened in Indian Country. As they move forward with budgets, there may come a time when CDC does not have the funding to travel for two meetings. Consideration could be given to alternatives, and about the best use of people's time. She would like for some of the planning meetings to move toward working meetings via teleconference. That way, some of the work is done before they have in-person interactions. She asked whether Mr. Antone thought they could provide feedback on the charter by September 16<sup>th</sup> as well, or if they needed to wait for the draft of the Tribal Consultation Policy.
- Mr. Antone responded that he thought they could submit comments on both simultaneously, given that the charter was only a few pages. It was agreed that members would submit comments for the charter by September 16, 2011 as well.
- Mr. Antone indicated that the pros and cons of all suggestions would be weighed to ultimately develop the charter and the consultation policy. He thanked everyone for their input on both documents. He expressed his hope that everyone provided their area reports, because these are very important to CDC in terms of understanding what is occurring in Indian Country. He also thanked everyone for submitting their biographies.

## Report from the Members

### Aberdeen

No report.

### Alaska

#### **Jay C. Butler, MD, Senior Director Division of Community Alaska Native Tribal Health**

Dr. Butler said he wanted to highlight health issues because there is a lot of overlap with what he observed in the reports from other areas. The list of health issues that he identified in his report (e.g., suicide, cancer, unintentional injuries, diabetes and other complications of obesity, oral health, alcohol abuse, tobacco, and STIs) was in many ways driven by a recent retreat with their board at the Alaska Native Tribal Health Consortium (ANTHC). Unintentional injuries continue to be the leading cause of years of potential life lost among Alaska Natives. Diabetes and other complications of obesity are increasingly recognized. Historically, Alaska Natives' rates of diabetes were quite low, so the rate of increase is very disturbing. The rates of diabetes among Alaska Natives currently align closely with the rates for non-natives living in Alaska.

Oral health is an issue of interest. This issue has been tackled head on through the court system and through a Dental Health Aid Therapist Program. There has been a lot of progress in this area working with the Kellogg Foundation. Alaska recently hosted about two dozen dentists from throughout the country. Following a number of presentations to orient the dentists to the tribal health system in Alaska, they visited Bethel, which is as close as one can get to an Alaska village without being in one. Some of the Dental Health Aids are only 20 to 21 years old, but they are very mature. They identified patients who would be willing to be treated while being observed. The dentists were divided into groups of four to accompany the Health Aids to observe patients being treated. Many of them came back saying, "Wow, we have never seen anything like this." The thing that most impressed them was the fact that the Dental Health Aids have an on-going program for their certification similar to physician certification programs. Nothing like this exists for dentists, so it was quite impressive. Alcohol abuse and tobacco are certainly issues that are being increasingly recognized and discussed. Sexually transmitted infections (STIs) is the one area in communicable disease where Alaska has not done very well. For example, Alaska continues to lead the country at either number 1 or 2 in chlamydia and currently has an epidemic of gonorrhea with rates having doubled in the past 3 years. For both of these infections, half of the cases occur in Alaska Natives.

In terms of activities, Dr. Butler thanked CDC for the grant for colorectal cancer screening using colonoscopy. There are three grants in Alaska, two to regional corporations and one to ANTHC. ANTHC works with 4 of the regional corporations. Because of the grant to ANTHC, over 300 people aged 50 to 80 have received screening. There are also a number of educational activities. One of these is the world premiere of a movie titled "What's the Big Deal" that was created in collaboration with the Arctic Slope Native Association. They also have a new character, Nolan the Colon, which is a giant inflatable colon people can walk through. Nolan makes the rounds around Alaska, where he was last seen in the Village of Eagle. Dr. Butler also acknowledged the three NPHII grants to ANTHC, one of which went to the Southeast ANTHC. Their Performance Improvement Manager (PIM) was the former Director for Public health at the state, and former Director of Public Health at the only local health department, which is in the municipality of Anchorage. They are doing a great job focusing on how to improve performance in the tobacco cessation program there. "I Want the Kit" at-home testing (IWTK) program began recently, which is a web-based resource for home testing for Chlamydia, gonorrhea, and trichomonas. This program is being conducted in collaboration with Johns Hopkins University. This program has been tested and is on-going in 8 states. Alaska is the first to have support to a tribal organization. The service is provided statewide to anyone in Alaska, not just Native Alaskans. They have received over 100 requests for kits so far, and will be assessing the results of these.

The 6 Winnable Battles may not be entirely aligned with some of the priorities reflected by the data on health status in Indian Country, both in Alaska and in the Lower 48. There continues to be very little benefit made obvious to Alaska by the accreditation process. There has been a lot of discussion regarding assistance with grants, fast tracking, or receiving extra points in grants, but Dr. Butler said there was nothing he could take to his board to make a case for this process. When they hear the word *accreditation*, they think of JAHCO. They have been reassured that JAHCO was studied as an example of what they should not be doing in public health accreditation, but there is nothing official coming out of CDC about that. In addition, there is a lot of data sharing with states and the counties through groups ASTHO and Council of State and Territorial Epidemiologists (CSTE), but this should be done more with tribal organizations as well.

### **Discussion Points**

- Regarding information going out, Ms. Cantrell indicated that CDC has the state, local, tribal, and territorial gateway. The premise is to have information in one central location for people to access, but it is also a means to push out information. She did not have much knowledge about it because it is in its infancy, but she said she would provide more information to everyone about it in the future.
- Dr. Butler said as an alumni member of ASTHO, he receives weekly updates, which he finds to be very useful.
- Mr. Antone noted that the issue of tobacco cessation was raised in the HHS consultation two or three years ago, and he wondered how that was working with chewing tobacco.
- Dr. Butler responded that Iqmik is chewing tobacco mixed with ash. It is a fungus that is burned. It is currently incorporated into their tobacco cessation program. He did not yet have the data on how this program is doing, but their performance improvement management project is to better assess this since much tobacco cessation focuses on cigarette smoking. They do have high rates of cigarette smoking, but smokeless tobacco use is extremely high in the Southwestern part of the state. In some areas, 30% to 40% of the population uses smokeless tobacco.
- Dr. Holzman stressed that CDC is constantly working to improve communications. Two of the resources include: "Have You Heard" and "Did You Know." "Did You Know" is information CDC distributes to the field, which has been in place for a while and people are beginning to recognize it. "Have You Heard" was recently started and is viewpoints from the field back to CDC and other areas in government. This is published every Wednesday. It would be nice to have something specifically for the tribes. For example, perhaps they could have one on the geographical area of tribes. This would be a good way to bring attention to the rest of government about tribal issues and activities. He asked Dr. Butler to elaborate on his comments regarding lack of feedback from CDC about the benefits of accreditation.
- Dr. Butler replied that the overall category would be if CDC could show that there is any advantage in terms of competition for extramural funds, and whether there will be a fast tracking mechanism for grant applications or grant management. If agencies could receive points in scoring if they are accredited, that again would be an advantage. There has been discussion in meetings about this for years, but it has not yet happened. He expressed appreciation to CDC for the native food efforts that are being supported through CDC. ANTHC has a program called "Store Outside Your Door." ANTHC did a webisode with contemporary chef Rob Kinneen from Anchorage who is Tlingit by birth, which will be premiered at the NIHB meeting in Anchorage in September. Raising awareness in Alaska about the "store outside your door" is Chef Kinneen's mission. He is a gourmet chef, but knows and works very well with some of the traditional foods. He had a recipe for fiddlehead ferns with blueberry reduction and seal oil written as if it were in an expensive restaurant.
- Ms. Cantrell noted that "Did You Know" is to be distributed through the Tribal Distribution List. She requested that those not receiving it should let her know so that she could be sure they were on the list.

## **Albuquerque**

**Lester Secatero, Chairman  
Albuquerque Area Indian Health Board**

Mr. Secatero began by congratulating Chester on his reelection, and said he thought he had been doing a good job. He reported that information is being disseminated through the Albuquerque Area Indian Health Board (AAIHB) meetings every month, as well as other health board meetings in the area. In the past year, they began a semiannual consultation with the IHS, which focuses on tribal governance of New Mexico and is working well with the tribal leaders. He indicated that public health issues identified by tribal leaders in his area that should be shared with the TAC include diabetes, cancer, behavior health, dental, heart disease, and injury prevention. Included in that would be substance abuse, suicide prevention, and depression. AAIHB has a new Area Director, Richie Grinnell, from Nashville.

In terms of activities, AAIHB has a colorectal cancer project. They had a hard time getting it off the ground because the local IHS did not want to run it through their location in Albuquerque. They wanted AAIHB to run it through the consortium in Alaska. They finally came to an agreement, so hopefully this project will work out. He has heard that Dr. Roubideaux is moving a lot of AAIHB's epidemiology personnel back to headquarters. They are doing well with their data at the IHS. There used to be a problem, but they have combined some resources with the help of the Area Director and are now doing pretty well. They have been meeting with the state. They recently met with the State Commissioner of Indian Affairs. There are Ute, To'Tohajiilee Navajo, Apache, and Pueblo sitting on the commission. AAIHB went round and round with them about the health situation on the reservation.

They have had a really tough time with the diabetes situation in his facility in Albuquerque because they had to change banks and it took a couple of weeks to get that straightened out. They were in danger of being shut down because they were not doing any draw downs, but with the help of Dr. Roubideaux's office, this was resolved. Another issue is that their Epidemiology Director resigned again, but he does not know why people keep resigning in Albuquerque. Their Institutional Review Board (IRB) situation is improving. They used to have to go through three locations (Albuquerque, Windrock, and Maryland), but now only have to go through Albuquerque and the Navajo Nation for approval. There has also been improvement with surveys in the area that help them with their grants. They learned that there is another Navajo tribe next to them about 70 miles away that has a problem with tobacco chewing, which they did not know about. There is not very much of this on his reservation. He noted that his written report includes a list of some of the activities occurring in the area. In terms of additional issues CDC and TAC should be aware of as they relate to AI / AN people in communities, his shop says there are too many tribal consultation meeting requests, which need to be streamlined. There needs to be feedback and implementation of recommendations. The federal agencies should work together to schedule consultation meetings. Also, it is difficult to reach people at CDC as a tribal leader, so he recommended that there be a Tribal Liaison for tribal leaders to contact. In terms of additional information they would like from CDC, it would be beneficial to have emergency preparedness information for tribes.

**Bemidji**

No report.

**Billings**

No report.

## California

### **Jackie Kaslow, MPH Family and Community Health California Rural Indian Health Board, Inc.**

Ms. Kaslow indicated that she planned to prepare a written submission as well. During this session, she reported on some of the issues that have been important to California in the last period. To begin with, one of the focal areas has been on their Tribal Epidemiology Center applying for refunding. In the process of developing an application and assessing some of the issues that have been of concern to them, they realized that the availability of data continues to be an interesting challenge in California. In particular, there is a significant problem with misclassification of Native Americans in the state that impacts their ability to apply for grant funding for very important areas. For example, they are assessing anecdotal information from tribal communities about a very significant upswing in suicides and suicidal ideation. CRIHB believes that this needs to be addressed as a public health issue in California, but they are highly circumscribed by not having really reliable data. Whenever she pursues funding for this problem, she has to make a major argument about why they do not have good data. That continues to be a big challenge. They believe that in part, suicidal ideation is linked to substance and alcohol abuse, so they are able to use some of their Substance Abuse and Mental Health Services Administration (SAMHSA) funding to try to examine the mental and public health issues pertaining to suicide. Until they have the ability to make a case for there being a significant problem, addressing this area remains challenging for them in terms of data.

Another area that CRIHB's tribes have identified as a major issue is teen pregnancy. CRIHB recently applied for the tribal Personal Responsibility Education Program (PREP) grant. There are very high teen pregnancy rates in various parts of the state, including some of the rural tribal areas. We are assessing this through the lens of the public health processes. Ms. Kaslow expressed gratitude to CDC because under the Public Health Internship Program, one of the interns was placed in their facility and will be fully paid for by CDC for the next two years. That person has been on board for three or four weeks, and already every department has been pulling him in all directions. She said she could not say enough for how much they appreciate having the extra help of that person. In addition to suicide, alcohol, and teen pregnancy, other areas of concern include sexually transmitted diseases (STDs) and sexual and reproductive health, obesity, type 2 diabetes, and cancer.

With respect to activities, CRIHB has two small injury prevention programs that are funded by CDC. Funding for one of these programs was awarded to CRIHB and one was awarded to one of their local tribal entities. Both of these programs focus on motor vehicle safety, seat belt use, and vehicle safety related to alcohol and substance use. Both programs are working with local tribal police in order to build their infrastructures and their capacities to deal with vehicle safety in their areas. That is a small, but very important win within that area. CRIHB is currently subcontracting on a small tobacco grant through the Intertribal Council of Michigan, which asked CRIHB to help them build an education materials and social marketing repository. CRIHB is very excited about doing that work. CRIHB had been funded by CDC for about a decade to deliver tobacco education, but no longer has those resources available. However, they are still active in this subcontract to address the issue. CRIHB was funded for a small project through the American Legacy Foundation to assess smokeless tobacco usage in California. Ms. Kaslow shared materials from this program with the group. Their approach was to address smokeless tobacco issues in dental offices, and the project went extremely well. Although it ended, they are still receiving requests for their materials and support system to help individuals stop



smoking and raise awareness and education. She would like for this information to be further distributed.

Regarding the public health accreditation issue, Ms. Kaslow has been active with the Tribal Advisory Committee. In California, and maybe some other places in the nation where there are many tribal governments and tribal communities in one state, the tribal communities are very small. Therefore, public health accreditation could create disparities if these entities do not have the capacity to achieve accreditation. Relative to the size of their budgets, the cost to become accredited could create a significant barrier to smaller tribes, resulting in an increase in disparities. Therefore, she was excited to see that CDC was considering having a delegate from CDC's TAC. Anecdotally, the State of California approached CRIHB about public health accreditation and requested that they create an educational module for their employees that would inform the employees about the accreditation initiative. This is an important point, because tribes are going to need to work with their local and state governments, which are not well-informed about public health accreditation, consultation, or whether their jurisdiction covers those tribes. This may also lead to significant barriers. CRIHB created a module for them, which is a first step, but she was somewhat alarmed to hear that they were not that knowledgeable about public health accreditation in itself. This makes her think that they may not understand what their responsibilities are in that endeavor either. This will continue to be a challenge, especially for California, if they do not receive more guidance about how to be successful at seeking accreditation for its communities.

### **Nashville**

**Tihtiyas (Dee) Sabattus, Director  
Tribal Health Program Support  
United and South and Eastern Tribes, Inc.**

Ms. Sabattus indicated that she had a written report that she would submit electronically. United and South Eastern Tribes (USET) has been sending information obtained from the CDC website or email blasts to tribes on a monthly basis. They also discuss various items during their monthly tribal calls. They also use a lot of CDC information within the Tribal Epidemiology Center population health reports. They publish a number of reports, including those on immunization coverage, mortality and natality data, STDs, oral health reports, et cetera. They established a relationship with the CDC Native Diabetes Wellness Program, so USET is promoting the diabetes education curriculum tool kits. One of USET's most current projects is a partnership between Vanderbilt University, USET, and Mississippi Band of Choctaw Indians. We are considering developing and having them use an electronic diabetes health tracking system. This was funded through Native American Research Centers for Health (NARCH). Some of the public health issues that this area continues to view as priorities include pre-diabetes, obesity, prescription drug abuse, and disposal of unused medications.

Some of the public health activities that are already implemented in in this area include reports created for USET's tribes. A yearly, local health needs assessment is conducted at one of USET's 26-member tribes. They also create community health profiles and diabetes reports. They are currently working with the White House Office of National Drug Control Policy (ONDCP) to create an Indian Country prescription drug abuse tool kit. She thought NCAI and NIHB were working on that as well. There are not any CDC-funded initiatives currently within USET; however, tribes within USET's area have some grants from CDC. USET used to have a grant from CDC through the Reach 2010 program, with which they created an immunization and child mortality resource and patient management system (RPMS) package for tribes to enter

their data. The only downfall with that mortality data was that it was not available. They had to purchase data from the tribes, which cost USET a lot of money. They had to work out agreements with 12. Some states provided the data free, but for others they had to pay a fee.

Data access continues to be a very important issue for USET. They continue to improve their population health reports. The more accurate data they have, and the more access they have to data, the further it benefits USET's tribes. As noted, they recently submitted their next 5-year Tribal Epidemiology Center cooperative agreement. They applied for the full \$1 million. While this was somewhat outrageous, one of the requirements within the request for proposal (RFP) was preparation of a separate budget for a Behavioral Risk Factor Surveillance System (BRFSS). When they began requesting bids for how much this would cost to contract it out versus doing it in-house, it was going to be an additional \$500,000 just to complete a BRFSS study on each of the 26 member tribes. Ms. Kaslow requested that CDC consider the provision of funding to assist tribes in completing these BRFSS studies. If the tribes were funded, the tribal BRFSS data could be compared to the state and national BRFSS data.

## **Navajo**

### **Rex Lee Jim, Vice President Navajo Nation**

Mr. Jim indicated that as Vice President of Navajo Nation, the President charged him with health and education. He began in January 2011 and did not attend the February TAC meeting, so he is new to this process. There is a Navajo Division of Health, with a Director and Program Directors. Through this division, information is provided to the Director's meeting, Community Health Services, and various programs. Navajo Nation also has web-based public health information. The Navajo Nation Council, the Legislative Branch of the Navajo Nation, gives reports to the Oversight Committee, the Navajo Health Education and Human Services Committee, and disseminates information through that committee. They also have chapter meetings and planning meetings. There are 110 chapters, which are small political units. During these meetings, Navajo Nation presents health issues. They also conduct conferences. For example, they recently held a conference on cancer that was attended by people from different schools. They have meetings with their 638 programs, and these programs also help to disseminate information through their systems.

In terms of health issues identified, since January 2011, the Navajo Nation has confirmed 11 new cases of tuberculosis. Approximately 250 people were exposed. Mr. Jim thanked CDC for their quick response to a request for assistance. It is important to cooperate more in that fashion in order to address health issues. The Navajo Nation also looks to CDC regarding tobacco. The Navajo Nation Council recently passed smoke free legislation. Unfortunately, the President had to veto it because there was an exemption for casinos. However, their belief is that Navajo Nation should be smoke free in all areas, including casinos. Secondhand smoke is dangerous, so they are working on this. Commercial tobacco-free legislation is being developed in collaboration with Mr. Jim's office and a non-profit group from Southwest Navajo that is very adamant about commercial tobacco free legislation. They are also working in the communities and with different organizations on that legislation.

Navajo Nation is also in the process of amending its HIV tribal code to include HIV screening. Since beginning screening, they have screened 716 new clients who have never been screened or who have not been screened in the past 5 years. Navajo Nation has a cooperative agreement with NPHII for performance improvement and plans to become a state-like

department of public health. They will change from a Division of Health to a Department of Health. Mr. Jim's office is also developing a Navajo cancer control plan to address the cancer concerns of the Navajo Nation. The plan is to assess the entire Navajo Nation code and to address and update all codes pertaining to health issues. The Navajo Birth Cohort Study is funded for three years through a cooperative agreement with CDC and ATSDR. As stated earlier, this needs to be funded fully and adequately so that there is enough time to give justice to the research. Currently, the time is too short and funding is running out.

As noted, one of the top priorities of the Division of Public Health is to become a Department of Public Health so that they can monitor, assess, and evaluate all programs. For example, they currently use a for-profit business organization to take clients from their homes to healthcare, but there are no policies to regulate them. They want the 638 programs under Navajo Nation so that they can make them accountable. Having a Department of Public Health will help to ensure comprehensive and culturally appropriate services. The Navajo Nation continues to seek additional funds from the different federal and state sources.

Some of the other health issues they are working on include diabetes, obesity, and suicide. Mr. Jim's office is planning what is called Run Across Navajo. The run will go from Alamo to To'hajiilee, then to Torian and across to Two West City and Bodaway. There will be booths along the way so that when runners stop, people will talk to them about various diseases. They want this to be big enough so that the entire Navajo Nation pays attention. They also want to tap into Navajo traditional games such as running and other traditional activities. They also have a "Just Move It" program that is very successful in Navajo, with about 300 attendees for each event throughout Navajo Country. They have also been working with a foundation to bring health activities to the school such as soccer and golf. Sports giants in Navajo Country talk to the students and children to tell them that they need to be more proactive in terms of exercise and healthy eating habits. They are also planning a health and education summit to bring health providers together to educate Navajos. Another issue is oral health. They met with the American Dental Association (ADA) President and the Arizona portion. They would like to reintroduce mobile units to go from chapter to chapter to schools in order to take the services out to the community. Another activity is bringing spiritual leaders, medicine men associations, and preachers together on a weekly basis so that they can talk about health issues through their sermons, medicine practices, et cetera to address all of these issues.

In terms of other issues Navajo Nation would like CDC to be aware of, direct funding from the federal agency to Navajo Nation would result in much faster program implementation. Regarding public health preparedness, the Navajo Nation is unique in that it is situated in 3 different states. Sometimes they have funding and programs that address geographical areas like Arizona. However, there may be a need just one yard over the state line. They need to set up funding and programming to address nearby areas in New Mexico or Utah. They have received funding to conduct the Navajo Medicaid Feasibility Study. Once this is in place in the Navajo Nation, it will be in a position to take care of its own Medicaid and Medicare. They would like to have tribe-specific health status reports from CDC. Technical support is needed in the form of a special assignment Public Health advisor to assist in addressing environmental and infectious disease on Navajo Nation.

## **Oklahoma**

**JT Petherick**  
**Health Legislative Officer, Cherokee**

Mr. Petherick reported that in terms of disseminating information, the Oklahoma Area works through the Oklahoma City Area Inter-Tribal Health Board (OCAITHB) and Tribal Epidemiology Center. For the Oklahoma City area, this includes Kansas, Oklahoma, and Texas tribes. They do a great job getting information out. They have similar issues as Mr. Secatero described in terms of the Tribal Epidemiology Center Directors growing frustrated and leaving. However, they feel confident that their current Director will stay for a while. One of the issues with turnover has to do with the difficulty obtaining data and legal wrangling with IHS and the federal government. It has gotten to the point that people become so frustrated they just move on because they cannot access data and do their jobs.

In July, the Tribal Epidemiology Center recently held their third annual epidemiology conference, which is national conference. Mileage and hotel accommodations are paid for attendees outside the area, which assists tribal public health personnel in being able to attend. A primary focus of the July conference was on the upcoming public health accreditation process. The Cherokee Nation has been a beta test site for accreditation within the area. Many tribes with smaller populations are ready to tackle the accreditation process and plan to apply this fall. There was a lot of discussion about the fees that PHAB is proposing for tribes, but based on what this includes, the fees seem reasonable. A lot of tribes in the Oklahoma City area have noticed the value received from pursuing public health accreditation and building up the public health system. From being a beta test site, the Cherokee Nation learned that they need to think differently about how they approach health. They have always been highly focused on IHS because that is where the large majority of resources come from to provide health services within the jurisdictional area. But they have to think much broader about the implications, and a lot of that has to do with their relationship with CDC. Mr. Petherick was very impressed with what the Navajo Nation is doing in terms of how they perceive and tackle health issues and thinking much broader than just health delivery. CDC can play a role in assisting tribes with understanding that message and what it means to talk about health, which is much more than just direct health care services. Another public health issue identified within the Oklahoma Area regards how to deal with funding cuts, and how cuts will impact many of the CDC activities already taking place that are affecting Indian Country. While he knew CDC did not know much about what the cuts would look like, it would help tribes to know how much the cuts are anticipated to be so that they can prepare.

Many of the larger tribes have been able to develop tribal community health profiles on their own, but some of the smaller tribes have struggled with that. The Tribal Epidemiology Center is important in this effort, but due to the turnover, it has been delayed. However, these activities are beginning to pick up. Tobacco prevention and cessation is always a major issue, particularly as they relate to gaming venues. Because of the way many of the tribes in the Oklahoma City area are situated, there is significant competition in terms of gaming venues. Therefore, it is really difficult to implement change because tribal leaders are concerned about how it is going to impact competitiveness with other gaming venues. They are having dialogue about the issue and are working with the University of Oklahoma to develop a plan to lay out the issues that need to be addressed before pursuing tobacco-free venues. Within the Oklahoma City area, there are a lot of long-term care issues. They have never really had clear authority within the Indian Health System to address a lot of long-term care issues. However, they now have some language that clearly makes a statement about long-term care, so they are starting to take the next steps. Funds are needed to provide for the elder population, and they need to determine the best way to approach health care for that population. Cherokee Nation and other tribes within the Oklahoma City area have done a great job in starting a dialogue about building healthier communities. It would be beneficial to begin sharing information about the healthy

activities taking place throughout Indian Country with tribal leadership so that others can implement such activities.

## Phoenix

### **Sherrilla McKinley, Health Project Specialist Tribal Health Steering Committee for the Phoenix Area IHS**

Ms. McKinley reported that information is received by the Inter Tribal Council of Arizona (ITCA) from CDC, and ITCA disseminates that to tribes in Utah, Nevada, and Arizona. ITCA has a tribal steering committee that consists of tribal leaders from Arizona, Utah, and Nevada. The steering committee has quarterly meetings during which information is shared with the tribes. The Phoenix Indian Health Service has a budget consultation meeting during which Arizona, Utah, and Nevada tribes discuss the budget and what health issues they want brought forth. As a group, they discuss and come to consensus on their top 10 priorities. The first priority is contract health services. Many tribes do not have access to care, so they rely heavily on contract health services dollars that are very limited for Indian Country. The second priority is diabetes, which includes obesity and renal failure. They are going to start seeing a rise in kidney disease because it is connected to diabetes. The third is behavioral health, which includes mental health and substance abuse disorders; fourth is cancer; fifth is oral health; sixth is maternal and child health, which includes adult childhood obesity and women's healthcare issues; seventh is healthcare facilities construction, some of which are very old; eighth is cardiovascular health, including heart disease and hypertension; ninth is elder health; and tenth is health promotion and disease prevention, which includes injury prevention, suicide prevention, and domestic violence prevention.

The Inner Tribal Council of Nevada has on-going public health activities, including the State of Nevada Substance Abuse Prevention and Training Project. They have members from the tribal government, state, and federal agencies. They have a tribal liaison program that is out of the Nevada Division of Environmental Protection, which also serves as the Women, Infants, and Children (WIC) state agency on behalf of the tribes in Nevada. There is also the IHB of Nevada, the focus of which is on behavioral health and chemical dependency. There is an annual youth summit to provide resources to students, and to motivate and educate them. There is also an Inner Tribal Emergency Response Commission. Their responsibilities include developing hazardous materials management training and emergency incident response coordination. ITCA's on-going public health activities are conducted by the ITC Epidemiology Center, which is one of the original centers that was funded in 1996 by the IHS. It serves the Arizona, Nevada, Utah region. They provide training, epidemiology, and technical assistance in planning and evaluating tribal health programs and systems. They provide data sharing between tribes and other health entities, data management and reporting requirements, and respond to disease outbreaks and clusters that impact the tribal communities. For example, they have observed a rise in cancer. They also arrange meetings about health and data issues, such as the diabetes data improvement to assist tribes in IHS. They have projects at ICTA, such as the American Indian Research Center for Health. They have the dental prevention and clinical support center, the WIC program, a community tobacco education and prevention program, an STD / HIV / AIDS prevention program, an environmental quality program, the tribal health steering committee, and the transportation injury prevention working group.

Public health issues need to be addressed across all disciplines at the tribal level. Though they heard it mentioned that a lot of times information goes to tribal leaders at the administrative level, sometimes it has a hard time finding its way down to the local level. For example, it is

likely that many communities are not even aware of the Winnable Battles because this information does not get filtered down to them. There must be a focus at the local level where outreach to the rest of the community is conducted. TAC members, through the support of OSTLTS, should be present at each of the regional tribal consultation centers of the HHS in fiscal year 2012 to further advance CDC tribal efforts, and to follow-up and obtain further advice from tribal leaders on policy concerns, budgetary matters, and public health strategies.

### **Discussion Points**

- Dr. Holzman acknowledged the challenge of getting information to those who are actually doing the work at the public health level. CDC gets into a catch 22 when they go directly to the local level, because the leaders expect them to be approached first. CDC can continue collaboration on both sides. He agreed that the information needs to get to the local levels, but they also must be respectful of leadership.
- Ms. McKinley thought perhaps a recommendation could be made for tribal leaders to obtain the advice from their public health departments. At one of the meetings, one of the tribal leaders asked if they could bring along their health director because they are the ones with the expertise. Many times, consultations only ask for tribal leaders. Sometimes tribal leaders may be new in that position and may not be aware of all of the health issues in communities. Tribal leaders are very busy and health issues may be pushed aside because they are dealing with economic development and other issues that may take top priority over some health issues. Sometimes they are not reading their emails because they have so much coming in and are very overwhelmed sometimes.

### **Portland**

#### **Joe Finkbonner, Executive Director Northwest Portland Area Indian Health Board**

Mr. Finkbonner indicated that there are logistics in terms of how NPAIHB communicates information that CDC passes onto its organization. There is a weekly mail out that is sent out to three different categories of listservs (e.g., Tribal Chairs, Tribal Health Directors, and Delegates). Sometimes these can be the same person, but often they are three different people. Information of importance is also posted on NPAIHB's website for general consumption. They also disseminate ad hoc bulletins. If there is something of an urgent nature, it will be sent out immediately to those same listservs.

There are several projects within Portland that NPAIHB has in common with CDC, either through a partnership or as a result of some funding from CDC. One is the Tribal Epidemiology Consortium, which was funded this year through coordination with ASTHO. NPAIHB is working with two other tribal epidemiology centers, California and Oklahoma. One of the projects that was completed and posted on CRIHB's website was an injury prevention tool kit, which has some great resources. Rachel Ford, the Performance Improvement Manager for the Public Health Infrastructure Initiative, has been working with some of the Portland tribes on projects to prepare them for accreditation. The Native Children Always Ride Safe is a child safety seat project that is a follow-up to a surveillance project conducted with CDC funding in which surveillance was conducted with 7 tribes about proper utilization of safety seats. NPAIHB is now helping to design interventions that would implement the findings of the surveillance project. The HIV / STD project through Project Red Talon is using social media and text messaging, which is similar to what CDC does with its public health alerts, with adolescents and

teenagers who have signed up for the service. NPAIHB recently hosted its 8<sup>th</sup> Annual Emergency Preparedness Conference to which all 43 of NPAIHB's tribes and Emergency Preparedness Coordinators are invited. Though not all attend, they are always made aware of the conference, which seems to be growing in attendance every year. Last year, there were approximately 300 participants. They try to balance the topics between emergency preparedness and public health preparedness so that there is a nice blend of the two, and it is also nice to get representatives for each in the same room to do some networking and coordination.

The major health issues that are impacting the Portland area are similar to other areas. Diabetes is still a major issue. In order to address this, there is a train-the-trainer event every summer in August in partnership and collaboration with Nike known as Nike Native Fitness. Individuals participate in two and a half days of intensive training so that they are prepared to help their respective communities. NPAIHB also conducts a Risky Business Training, which is somewhat different because in tribal populations, the diabetes project may be targeting the same person that the Cancer Prevention Project is targeting. Following a tribal site visit, someone may be preempted by their counterpart who has already been there. They now hold three one-day trainings each year that includes the cancer, HIV / STD, and the prescription drug abuse projects with the coordinators from the tribal programs. These have been conducted in regional areas, and have even been done from the NPAIHB office using iLink in partnership with the Northwest Center for Public Health Practice. NPAIHB tries to find different ways to reach out to more of its population in a way that is friendly to everyone's schedules. In terms of what information NPAIHB would like from CDC, increased coordination with other agencies would be beneficial. During the week of this TAC meeting alone, three consultations were going on. It is very difficult to have all of the right people in every meeting if they are split three different ways. NPAIHB would also like more information coming from CDC in terms of holding states accountable for effectively working with tribes.

## Tucson

### **Chester Antone, TAC Co-Chair Councilman, Tohono O'odham Nation**

Mr. Antone reported that information is shared primarily via email and through their Tribal Council representatives. The Tribal Council will disseminate his reports to their districts, and they provide a verbal report to their District Council. Email forwards are done to Pasqua, and Tucson will be setting up a meeting with them because of a number of issues, such as Medicaid issues. Tucson representatives also share information with the national committees on which they sit.

Transportation is a major issue in terms of diabetes. Tucson is in the process of developing maps and numbers that relate to referrals for specialty clinics to present to CMS. Type 2 diabetes is 19.9% at this time, which is the highest in the nation. They are working to convince people to exercise. Tucson received a cancer planning grant, which they need to implement. There was a drought this year even though they are in the monsoon season, which has given them a lot of rain. However, they have not had much rain for the past couple of years, so they are going to run into drought. The wildlife are approaching the villages. They are not afraid anymore because they need food. There is a concern about rabies and children playing outside. The All Hazards Conference is being planned. Posters and announcements went out through KOHN 91.9 FM, which went international last month and is now streamed to the internet. An STD epidemic was declared over by the Tohono O'odham Legislative Council three

years from the day it was declared as an epidemic. STD has been reduced to normal levels, but they are increasing prevention efforts to avoid future problems. Reaction to an epidemic takes a lot of resources and work, so the time to engage in prevention is when there is no epidemic.

Ground water contamination at one of the former mines is still an issue, as are possible animal diseases. There was recently an equine virus situation in the Tohono O'odham Nation. A tri-national group from the Environmental Protection Agency (EPA), the Tohono O'odham Nation, and the state is trying to work with Mexico to determine how they can address those issues. This is mainly for fires. There is a fire burning from Mexico across into the United States, so there are a lot of coordination issues. Hopefully, a tri-national plan will be developed that can quickly address animal disease, fires, et cetera. The international issue has been brought to CDC's attention every year in prior consultations, but CDC has never responded to the international side, specifically in terms of native tribes on the borders. NCAI sent out an email about the mid-western flooding and tornadoes. Mr. Antone emailed CDC to ask whether TAC had a role to play in assisting tribes, but he has not received a response. He believes someone has been designated to address issues such as this, although he did not know whether the Division of Emergency Operations Center (DEOC) at CDC was still there with the walls of monitors to monitor every disease outbreak internationally. It seems that they do not really look at the native side because maybe there are not any epidemics in the native community and there is not a concern there. If there ever is, native tribes need to be informed of it if nothing else. The TAC is advising CDC, and CDC should at least provide information to say that they have responded in one way or another.

### **Tribal Self Governance**

No report.

### **Direct Service Tribes**

#### **Marlene Redneck Billings Area Representative**

Ms. Redneck noted that she is new to the Tribal Leaders Organization. There is an epidemiology center in the Billings area that is new and just getting started. One of the main issues raised in the Tribal Leaders meeting was about data being collected and disseminated back to the tribes for them to use. Other issues include diabetes, behavior health, and mental health. In the Billings area, there have been numerous suicide attempts and, unfortunately, a lot of successful suicides. Groups have been formed in separate tribes to address suicide prevention. On her own reservation, the group that is supporting this received funding from Montana State University to set up a focus group. They have been educating the public schools. Last fall, a student committed suicide because he was being bullied in the school. He could not take it anymore and went home and completed suicide. There was a lot of education done, and that group is really going strong. They have come to the Montana and Wyoming Tribal Leaders Annual Health Conference and presented what they have done in order to share with other tribes.

Another area of concern is cancer, which ties into contract support as most of the Direct Service Tribes do not have access to specialized services to detect cancer with additional testing. Therefore, cancer is often detected in the last stages. She is Northern Cheyenne, and cancer is the number one priority there. Diabetes used to be a significant problem, but because of the



efforts of the Diabetes Prevention Program, diabetes is not increasing, but cancer is increasing. Additional health priorities include heart disease, health promotion and disease prevention, alcohol and substance abuse, prescription drug abuse, dental health, injury prevention, maternal and child health, and water and sanitation.

Partnerships among agencies are very important. Often, by the time the Direct Service Tribes receive information about grants, it is already too late to apply. There needs to be better communication. Montana is fortunate to have Anna Whiting Sorrell who is at HHS. They do have a connection with the state there. However, it might not be too long before there is a new one. It is really important to work with the states to disseminate information. It would be very beneficial for CDC to get information out to the tribes in the communities.

### **National Congress of American Indians**

No report.

### **National Indian Health Board**

No report.

### **Tribal Self-Governance Advisory Committee**

No report.

## **CDC Presentations**

### **Arctic Investigations Program Overview and H1N1 Discussion**

**Thomas Hennessy, MD, MPH**

**Arctic Investigations Program (AIP)**

**Division of Preparedness and Emerging Infections**

**National Center for Emerging and Zoonotic Infectious Diseases**

Dr. Hennessy offered an overview of the Arctic Investigations Program (AIP), as well as an update on H1N1 influenza. Out of recognition of special needs and problems facing people in the far North related to infectious disease and other public health problems, the US Public Health Service (PHS) formed the Arctic Health Research Center in 1948. This was formed the same year that CDC was established in Atlanta, Georgia. The Arctic Health Research Center engaged in a number of activities related to infectious disease threats, water and sanitation issues, and issues related to other concerns about living in the far North. In 1973, the infectious disease components of the Arctic Health Research Center became part of CDC and the operation was co-located on the Alaska Native Medical Center (ANMC) campus in Anchorage, where a close relationship has been maintained ever since. In 1997, ANMC moved to new facilities and IHS did something really remarkable by building a new laboratory for CDC. Dr. Hennessy said he was told that it is probably the only example of one federal agency building a building for another one. The AIP has enjoyed using that building ever since. The laboratory was completely renovated last year and now has a state-of-the-art infectious research facility located on the ANMC campus.

The mission of the AIP is “to prevent infectious disease morbidity and mortality in people of the Arctic and Subarctic, with a special emphasis on diseases of high incidence and concern among indigenous people.” Missing from the mission is the word “Alaska,” given that the AIP really views itself as having an international as well as a domestic focus. They work closely with partners in Canada, Russia, and the other Circumpolar nations. The word “indigenous” is used because of the AIP’s sensitivities for its Canadian colleagues. Approximately 75% of the AIP’s work is focused on health concerns related to AI / AN. The AIP’s priority areas include surveillance, emerging infectious diseases, health disparities, preparedness and response, and leadership in Circumpolar health.

The Alaska Area Specimen Bank houses a collection of specimens for which the AIP is the steward. These specimens have been collected during research and public health investigations since the 1960s. These are maintained for the health benefit of the Alaska Native people under an IRB-approved research protocol. The management structure includes Alaska Native tribal leadership who help decide what specimens are shared and collected and how they are used. The samples consist primarily of blood (sera) specimens (n=~ 300,000) from approximately 92,000 persons of whom 80% are Alaska Natives. There are also microbiologic isolates and human tissue. This is a unique federal / tribal partnership in the management of a specimen repository.

Turning to the topic of influenza, Dr. Hennessy shared a story about influenza in the Alaska region of Nome. The following Northwest Alaska map shows Russian in the upper left hand corner along with the region of the Seward Peninsula, in which the largest community is the village of Nome:



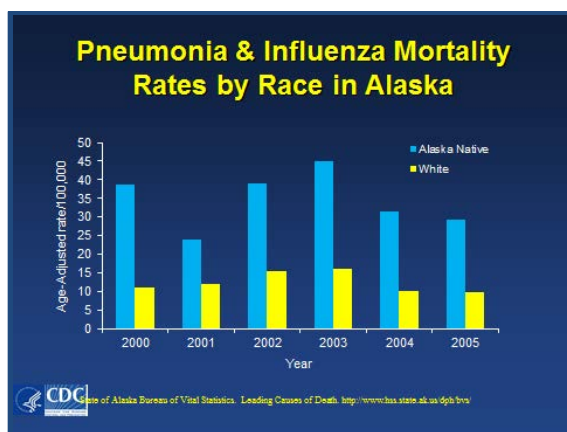
Nome is the end of the very famous Iditarod Trail Sled Dog Race, which begins in Anchorage and ends in Nome and signifies a very important public health event. In 1925, there was a diphtheria outbreak in Nome and there was a need for antitoxin to be delivered to the community. A relay team of sled dogs was used to get the antitoxin to the community, and this is commemorated by the Iditarod Sled Dog Race. What is lost somewhat to history is an event that occurred just 7 years before the first Iditarod race that had to do with an event related to the great influenza pandemic of 1917 and 1918. This story began in October 1918 when the marine vessel Victoria was the last ship of the year delivering supplies and people to the village of Nome. Three passengers had been removed from the vessel in Seattle who had influenza. Because of that, the ship was held in quarantine for 5 days until October 25, 1918 when the passengers were released. Unfortunately, this did not work and the first influenza cases were

reported in Nome residents on October 25, 1918. Influenza spread rapidly in the village and to other villages along the coastline, it is believed through mail and supplies that were carried by dogsled.

Influenza is both the name for an illness and for a virus. The illness is a respiratory infection that causes fever, cough, sore throat, runny nose, muscle aches, headaches. It ranges from mild illness to a life-threatening condition and is spread by droplets from cough, sneezing, and being very close to someone. The virus itself is divided into two main types that affect humans. The first is Type A, which has an outer protein known as the H protein of which there are 16 types. Type A also has an N protein, which has 9 types. The second is Type B.

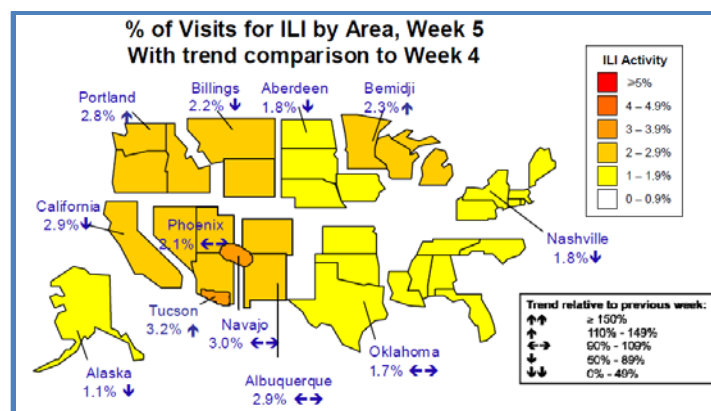
As noted, influenza found its way to Nome in 1918. It spread rapidly and had disastrous results. This was a new virus to the world that had never been seen, at least in Northwest Alaska and at least that strain. Of the AN population, 40% died that fall. Of Nome's population (n=200), 175 died within a short time. Influenza spread throughout the Seward Peninsula. Interestingly, some villages were able to avoid the epidemic by posting guards on the incoming trails and turning away the mail carriers and dog sled teams that would have come into their communities. This is one of the few examples in which quarantine actually worked in this particular type of pandemic. One of the communities that was very hard hit was the Brevig Mission where 72 of the 120 people living there died. All of those folks were buried in a mass grave that was about 2 meters deep and set into the Permafrost. Despite their tragedy, the descendants of the people of Brevig Mission made a great contribution to those of us alive now. In 1997, they allowed researchers from the Armed Forces Institute of Pathology to remove some of the lung tissue from some of the buried victims of the 1918 influenza pandemic. The scientists at CDC and the Armed Forces Institute of Pathology were able to take sequences from that virus found in lung tissue and characterize it to a great deal to learn more about this terrible virus that spread around the world. The generosity of the people of Brevig Mission marked the first glimpse into the inner workings of the virus. That virus was named A/Brevig Mission/1/18/H1N1, and it was the prototype of the virus that was circulating around the world. There are other stories about pandemic influenza from 1918, some of which were captured by HHS in the *Pandemic Influenza Storybook*. The stories are from quite compelling voices from the past that tell us about the dissemination of the 1918 influenza. They have really left a mark on American history and are important stories that helped inform preparedness for pandemic influenza and the thinking about how to prepare tribal communities and other groups for influenza.

Unfortunately what happened in 1918 was not isolated. AI / AN continue to suffer greatly from excessive rates of influenza mortality and morbidity. Data from the State of Alaska show much higher rates of deaths due to pneumonia and influenza among AN persons compared to the white population. A similar graphic could be created for nearly every other state where there is a large AI population [State of Alaska Bureau of Vital Statistics. Leading Causes of Death. <http://www.hss.state.ak.us/dph/bvs>]:



The year 2009 marked the start of a new influenza pandemic. In April 2009, a new virus was isolated from a 10-year-old child living in California. The new virus had swine components and was quickly demonstrated to be spread person-to-person. It created an unusual spring peak in influenza after there had already been a typical winter influenza outbreak. By June in the US, the virus had spread and caused illness in all 50 states. The World Health Organization (WHO) declared a worldwide pandemic for this new virus. There was a great deal of concern at the time that there would be a repeat of 1918, so many wheels were set into motion. CDC quickly activated the DEOC as a control point for coordinating activities in response to the pandemic, and enhanced the Strategic National Stockpile (SNP) by adding antiviral medications that could be used for treatment, as well as respiratory protection supplies such as masks, gowns, and gloves. The virus identified from the California child and others was isolated and set into motion vaccine development for a new specific vaccine against this new virus. CDC also developed recommendations for treatment and vaccination that helped guide the US response later that fall, and organized the National Vaccine Campaign that involved dissemination of seasonal influenza vaccine and the new 2009 H1N1 vaccine.

While this response was underway on a very broad national scale, there were other activities related more specifically to AI / AN persons. Early in the outbreak, it was recognized that H1N1 influenza was harming indigenous populations in the US and other countries. There were early reports of severe illness from Arizona, New Mexico, Manitoba, and the province of Nunavut that all involved indigenous populations. IHS moved very quickly to create an Influenza Awareness System that monitored the IHS electronic health information system. This was basically a computer software “patch” that could be activated at the facility level that would allow IHS to monitor influenza outpatient visits and hospitalizations, trends, vaccination coverage, and potential vaccine-related side effects from the use of the new vaccines. This was quite a novel innovation, which received an HHS Special Innovation Award in 2010. Approximately 60% (300/498) of IHS/Tribal facilities participated. As a result, these facilities were able to monitor their own influenza-related activities at their facilities. This also allowed IHS to post weekly reports on their website. The peak was observed during weeks 32 to 42, which would have been in August through October of 2009 [IHS H1N1 website: [http://www.ihs.gov/h1n1/index.cfm?module=dsp\\_h1n1\\_sr](http://www.ihs.gov/h1n1/index.cfm?module=dsp_h1n1_sr)]. They also posted regional profiles that were able to show on a broader scale what the epidemic was doing in different IHS areas across the US. The following illustrates a color coded approach to determine how severe the outbreak was and whether it was increasing or decreasing:



IHS H1N1 website: [http://www.ihs.gov/h1n1/index.cfm?module=dsp\\_h1n1\\_sr](http://www.ihs.gov/h1n1/index.cfm?module=dsp_h1n1_sr)

This information was used to help with vaccine planning. When this information first became available and there was a vaccine, some of the vaccine for health care providers was sent preferentially to New Mexico where the epidemic seemed to be the most intense at that time to make sure that health care providers within IHS could be vaccinated. This was a very helpful tool that allowed them also to track H1N1 vaccine doses throughout the IHS system. While that was going on within IHS, there was a recognition within CDC that special attention should be focused on the needs and concerns of AI / AN populations. CDC formed an AI / AN Populations Team that became part of CDC Emergency Response structure. The goals of this team were to monitor the pandemic in AI / AN populations and to assist with and advise about communications to provide liaison activity with IHS and other parts of the federal system, to address policy concerns, and to conduct or help support any special investigations that needed to be conducted to address concerns within tribal communities.

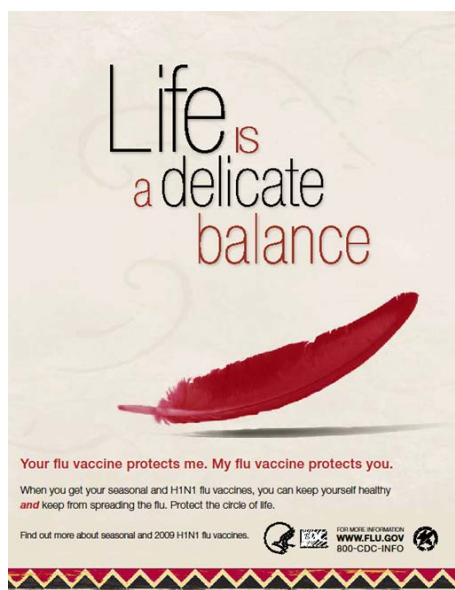
It was quickly recognized that there was no central point in the CDC web pages for tribal members or tribal leaders. Within the CDC influenza web pages, there was a Tribal Health Officials page, which basically contains postings and linkages for Tribal Health Officials and tribal members to obtain information specific to their needs in terms of pandemic influenza. There was also a need to provide specific information about influenza that was tailored to particular audiences, so CDC tailored specific messages for print materials, public service announcements (PSAs), et cetera. Cherokee actor Wes Studi assisted CDC with the PSAs, which Dr. Hennessy played and which can be viewed at the following:

<http://www.cdc.gov/CDCTV/CircleOfLife/index.html>

<http://www.cdc.gov/CDCTV/Take3/index.html>

This poster is an example of some of the print materials that were developed:





A number of special investigations were developed during the pandemic flu response at CDC. An influenza telephone survey was conducted under the Behavioral Risk Factor Surveillance System (BRFSS) from September through October 2009. What differed about this survey was that BRFSS surveys typically do not include enough AI/AN persons to draw conclusions about any particular concerns in these populations. This oversample of AI/AN persons allowed CDC to assess the prevalence of influenza-like illness (ILI) symptoms in the population. During the height of the pandemic from September through October 2009, 16% of AI/AN adults developed influenza symptoms versus 8% of the overall US adult population. This confirmed the concern that there was more prevalence of influenza symptoms in Native populations. A validation study was conducted of the IHS electronic health records for influenza monitoring to ensure that the electronic records matched well with the paper records. This was done for influenza illness and pregnant women at risk. A special study was conducted that pertained to influenza hospitalizations among Alaska Native persons that resulted in information specific to the State of Alaska, and there was a multi-state effort to evaluate increased risk of death among AI/AN persons.

A 12-State Working Group was organized through CSTE and CDC that included state health departments, local health departments, and tribal epidemiology centers. CDC compiled data from all of these resources to evaluate the risk of death among AI/AN. They found that the death rate in those 12 states was 4 times higher for AI/AN compared to any other race in those states. They also found that the risk of diabetes and asthma, predisposing conditions for severe influenza illness, were 2 times higher among AI/AN who died compared to other populations. Data from this effort were published in the *Morbidity and Mortality Weekly Report (MMWR)* on December 11, 2009, which turned out to be a very influential document that allowed CDC to take a few steps forward.

There are some potential explanations for the increased risk of death among AI/AN and the higher rates of influenza among tribal communities. With more influenza illness, there is a greater risk for people to become ill and die. There is also a higher prevalence of risk factors for severe illness such as diabetes, end stage renal disease, and childhood asthma that could predispose AI/AN for death. Reduced access to health care is also a contributing factor. Many

native people live in remote locations where there are fewer health care providers, and where they might delay treatment or seek access to care in a different way. There is also a question regarding genetic susceptibility in terms of whether AI/AN are more susceptible to influenza. However, there are no known differences in the response to the vaccine or the severity of illness among native people compared to non-native people.

It was the feelings of the 12-State Working Group that more must be done to understand what the potential risk factors are for death due to influenza among AI/AN persons and persons of other races, whether these risk factors differ from other Americans, and which of these risk factors could be used to help prevent deaths due to influenza. In addition to a follow-up study, some of the states in the 12-state study also developed a secondary study that is on-going. The objectives of the follow-up study are to determine the risk factors for death due to influenza among AI/AN persons and persons of other races in all 12 states participation to determine whether those risk factors differ from other Americans. The method being used is a case-control study comparing the characteristics of 207 persons who died from H1N1 influenza in 2009 with 414 persons who were seen with influenza in outpatient clinics in those states. Information is being collected through medical chart abstraction (demographics, illness severity, underlying health conditions, treatment received, and complications) and through interviews with case families and clinic patients (access to health care, health behaviors, home living environment). Data collection is currently underway, and on-going analysis and reporting of results are anticipated sometime in 2012.

Regardless of the cause of the increased risk, AI/AN populations appear to be at increased risk. Therefore, it is important to promote community education and preparedness activities, the appropriate and early use of antiviral medications and influenza vaccination, and to conduct improved surveillance for influenza.

As a result of the pandemic, there have been some recent policy successes that should make it easier to prevent influenza during future events or in times of vaccine shortages. The US Advisory Committee on Immunization Practices (ACIP) at CDC is the group that sets policy for the US about how vaccines, and in some cases medications, are used for vaccine-preventable diseases. During the pandemic, there was no special consideration for AI/AN populations as a high risk group, but that has changed partly as a result of the information that has come out through the pandemic. In June 2010, ACIP recommended that AI/AN persons be added as a high risk group for vaccine recommendations and prioritization. Had this been available at the time vaccine distribution was underway, vaccine distribution would probably have been approached differently in AI/AN communities. In January 2011, AI/AN persons were added as a high risk group for influenza complications and were recommended for antiviral treatment prioritization. Both of these steps should help with prioritization and planning for future influenza seasons and pandemics.

In summary, AI/AN populations are at increased risk for influenza illness and death. CDC efforts during the influenza pandemic in 2009 tried to include the needs of AI/AN populations in planning and response, engaged in special efforts to communicate with tribal communities, and developed information specific for AI/AN populations. The agency has also made vaccine and antiviral medications more available to AI/AN persons, and is working to better understand the risk factors for illness and death to help with prevention activities. Dr. Hennessy noted that he has worked on many outbreak investigations with CDC and has never seen the special use of an AI/AN Populations Team to address the particular needs of this group as was done during the pandemic. He emphasized that this is a model to follow in the future in terms of special communication efforts, making vaccine and antiviral medications more available and accessible

to AI/AN populations, better understanding the risk factors for illness and death, and development and implementation of prevention activities.

In terms of next steps, it is important to continue to promote consideration of AI/AN concerns during public health response events. It is a tribute to the work for the TAC and the efforts by CDC to reach out and to form bridges of communication to help bring concerns into the process of CDC's response and planning. The pandemic influenza response is a success story toward that effort. As mentioned a number of times during this and the February 2010 TAC meeting, there is a need to strengthen data collection to include AI/AN race status in CDC and other state collection information systems. Part of the concern that arose, and the reason it was necessary to conduct a multi-state study in 12 states was that the information was not available in the routine collection of data through CDC. It is hoped that the collection of this specific information will continue to reduce the risk of influenza among AI/AN persons.

### **ATSDR Updates**

**Annabelle Allison, Tribal Liaison  
Office of Tribal Affairs  
National Center for Environmental Health  
Agency for Toxic Substances and Disease Registry  
Centers for Disease Control and Prevention**

Ms. Allison first thanked Dr. Dearwent for making the trip and for being willing to elaborate on the Navajo Birth Cohort Study. She also thanked two colleagues who joined her for this meeting, Chinyere Ekechi and Montrece Ransom.

As mentioned earlier, Ms. Allison noted that one of her activities involves the National Tribal Environmental Think Tank. This group is comprised of 12 professionals from across the country who are working with her to establish priorities that are going to be incorporated into a 3 to 5 year strategic plan that will be applicable to NCEH and ATSDR. The first meeting of this group was convened in July 2011 in Washington, DC. During that first meeting, presentations were delivered about the services that NCEH and ATSDR provide. This included discussion about how these services could be applied to tribal activities. During the second meeting, scheduled for August 25<sup>th</sup>, they plan to begin hammering out the bigger issues to determine some workable priorities based on the big topic areas. By the third meeting, the hope is to have finessed a list of priorities to address within 3 to 5 years and develop a skeletal strategic plan to accomplish those priorities. The third meeting will be convened in Anchorage, Alaska and will connect with NIHB's annual consumer conference. The Task Force will meet before the NIBH conference for 1.5 days to develop the skeletal plan, and then will present it for the first time at the NIHB conference. They are very excited about this.

Over the past year, Ms. Allison has also been working on a revised curriculum called "Working Effectively with Tribal Governments." This course was conducted in Atlanta on June 21-22, 2011. It is a training course that is offered internally to CDC and ATSDR colleagues. For the first time, this course was expanded to two days. The course covered American Indian history, tied in some public health impacts that resulted from that history, and addressed the roles federal agencies play in addressing AI/AN issues. There was discussion regarding ways the federal government could work effectively and consistently with tribal governments. It was a really good course, and excellent feedback was received from the participants about what they learned. A number of individuals indicated their plans to try to apply what they learned to their day-to-day program activities. The instructional team who assisted in revising the curriculum included a number of external tribal professionals, including Michael Byrd is a member of the



Santo-Domingo Pueblo in New Mexico, a former American Public Health Association (APHA) President, and has experience working with IHS; Patrick Bohan from East Central College, a former CDC staff member who understands the inner workings of the agencies and serves as a professional in public health topics; and a woman from the Occaneechi Band of Saponi Indians from North Carolina, a state-recognized tribe.

Another item of interest lately has been the NCEH and ATSDR reorganization. As far back as 2008, ATSDR has had to go before Congress to give testimony on various environmental health activities that they were conducting in communities. Unfortunately, they have received a lot of criticism from lawmakers about the way that ATSDR has been conducting their studies and whether they have been seeking information that would help some of these studies. There has also been a belief that perhaps ATSDR has been trying to hide things. They wanted to change that and make the agency more transparent. Therefore, the agency director has engaged in a reorganization process. They just went through the first round of the process with the ATSDR side, and are in the process of assessing NCEH's current setting to determine whether changes are needed there as well. The most important issue related to the reorganization is what it means for Ms. Allison's office, the Office of Tribal Affairs (OTA), particularly with respect to where the office will reside and to whom it will report. OTA was created under ATSDR in 1999 and served the Division of Health Assessment and Consultation (DHAC). This arose out of a need to have a mediator between tribes and the federal government on some of the health assessments being conducted in Indian Country.

In 2007, a group of tribal professionals convened and made recommendations to the leadership, one of which was that OTA should reside within the Office of the Director (OD) and it should serve both NCEH and ATSDR. The agency director agreed, and OTA was moved. The current complication is an odd connection to the Office of Policy, Planning, and Evaluation (OPPE) where OTA first sat and the OD. The most recent connection is OPPE and the Director. The good news is that Ms. Allison has access to and works very closely with the Director on certain topics. What will be beneficial in terms of reorganization is making a distinction regarding where OTA should reside, who it should report to, and the main purposes of that office. She has submitted comments to the Director. The most important issue is for OTA to promote and have a commitment to tribal sovereignty, and movement of OTA as a direct report to the Director would have federal consistency. Other agencies do this in a similar setting. CDC just went through this with its position in OSTLTS. The other benefit of being a direct report to the OD is that it offers flexibility and cogency to work with NCEH and ATSDR divisions. Ms. Allison requested tribal input once the public comment period opens in terms of support for where OTA should reside and some examples of why it would benefit the OD to have this office situated as recommended.

### **Navajo Birth Cohort Study**

**Steve Dearwent, PhD, MPH**  
**Branch Chief, Health Investigations Branch**  
**National Center for Environmental Health**  
**Agency for Toxic Substances and Disease Registry**  
**Centers for Disease Control and Prevention**

Dr. Dearwent reported that in 2009, CDC was made aware that Congress was going to allocate funding to ATSDR and CDC to conduct health studies of the effects of environmental exposure to uranium on the Navajo Reservation. As is typically the case for Congress, they were given two very short statements beginning with "thou shalt" and limited details. When the agencies

learned of the funding, they engaged in due diligence to determine what had already been done scientifically to understand the effects of uranium exposure in the Navajo population. A significant amount of work has been done with regard to occupational cohorts of miners and millers who were exposed to uranium. As a result, there is a substantial amount of information about the effects of uranium exposure in these settings. It is important to avoid duplicity, so the agencies would like to take this opportunity to assess other possible outcomes and exposure scenarios and conduct some public health research, also have some applied public health benefit with the project.

Ultimately, a decision was made to conduct a prospective study. Congenital anomalies are the leading cause of infant deaths on the Navajo Reservation. Limited epidemiological and toxicological data are available on the association between uranium exposure and adverse birth and reproductive outcomes. There is an increased exposure potential on the reservation because of historical mining and milling operations, and Navajo mothers are a well-defined, accessible cohort. The benefits of conducting a prospective study are that biomonitoring for uranium in the urine can easily be done, and a major caveat in environmental epidemiology can be addressed—exposure assessment. Designing and conducting epidemiological studies of health conditions among Navajo mothers and their infants potentially associated with non-occupational exposures to uranium released from past mining and milling operations on the Navajo Nation would result in information about exposure at different points that may differ during critical development states. Priority areas are health outcomes associated with uranium exposure during prenatal, perinatal, and early postnatal life periods. If uranium is a teratogen, epidemiological studies are needed to document individual exposure levels to uranium that cause effects. The study has both research and applied public health implications. One applied public health benefit will be helping Navajo mothers increase their utilization of prenatal care. Navajo women typically underutilize prenatal care, and often do not present to either Western medicine doctors or traditional medical doctors until later in their pregnancies. Many partners are helping CDC / ATSDR with this study. The study is not yet underway, but the last IRB meeting was expected to occur soon with the Windy Rock and Navajo IRBs. IRB approval has been received from the University of New Mexico and CDC. An Office of Management and Budget (OMB) review will be required next, and the hope is to have the study in the field sometime in early 2012.

With respect to what is known, there is strong evidence linking the early and consistent use of prenatal care with positive reproductive results. Only 61% of Navajo mothers with live births receive prenatal care in the first trimester as compared to 83% of all US mothers. Infant mortality rate among Navajos is 8.5 deaths per 1000 live births, compared to 6.9 deaths per 1000 live births among all races. Postnatal mortality rates for Navajo infants are 2.1 times higher than the US for all races. It is important to know this and the risk of exposure, particularly if there is continued pressure to resume mining on the Navajo Reservation and perhaps other parts of the US.

Regarding the project timeline, the planned project period is 3 years. ATSDR received \$2 million in allocations in FY 2010/11 and anticipates another \$2 million allocation in FY12. The University of New Mexico was funded as project lead in September 2010 at \$1 million annually. IHS and Navajo Division of Health were funded at approximately \$375,000 on an annual basis to conduct medical aspects and community/participant outreach, respectively. As noted, IRB approvals are still in process and the OMB package must be submitted for review. It is anticipated that field work will begin in early 2012. CDC and ATSDR are tasked with oversight of the effort, as well as biomonitoring through the agency environmental health laboratories. It is anticipated that this will result in approximately 4,000 or 5,000 individual measurements of

urine for uranium, arsenic, and some other heavy metals of concern that may confound any associations. The University of New Mexico, through a research cooperative agreement, is playing a lead role in the study design and implementation. The Navajo Division of Health is going to contribute significantly to community outreach, education, and interaction with participants. This will help to deal with the cultural and language barriers that are anticipated to be encountered. IHS will assist with the medical aspects of the study in terms of seeing the moms during their prenatal visits and utilizing their medical records management system to follow the children post-birth for many years.

### **Discussion Points**

- Mr. Antone wondered whether the study would be able to determine exposure between the mines versus naturally occurring uranium and the impacts of each on the women and children.
- Dr. Dearwent replied that the primary focus of the health outcomes component of the study is to assess whether there are impacts on children in terms of reproductive birth defects and / or developmental delays later in childhood. With regard to exposure, optimistically, for every mother recruited into the study, there will be biomonitoring to understand their body burden of uranium at each trimester and possibly post-birth. It is tricky to assess overall body burden in terms of whether the burden is from naturally occurring high levels in the soil in the Southwest or from other sources such as mining or milling. There will also be home assessments to try to identify whether there are current sources of exposure that are of concern. The federal EPA is being contacted to make sure that their environmental assessments include the areas in which the residents live. Ultimately, the intent is to try to address the source attribution whether it is from an environmental media such as the soil near their homes, dust within their homes, or radon levels.
- Mr. Jim pointed out that the Navajo Nation does not perceive this study to be sufficiently comprehensive to address many of the health impact issues pertaining to uranium exposures. The Navajo Nation is also asking for adequate funding for long-term, comprehensive health assessment research on the impact of uranium and the Navajo population. During the third year, Navajo Nation is asking the study team to reevaluate whether carrying forward, or a no-cost extension, should be allowed to extend the timeline. Moreover, they would like to know how the investigators plan to use the study results when the study is over.
- Dr. Dearwent responded that the investigators hope the information gained will help to better understand whether there are associations between uranium exposure and adverse reproductive outcomes, developmental delays, et cetera. If that is truly the case, it will provide an evidence-based ability to try to address those issues more proactively. Should a positive association be discovered, it will be the "smoking gun" to justify focusing more effort into dealing with those concerns. If an association is not found with the uranium exposure and adverse outcomes, at the very least, the applied benefit of educating moms to seek prenatal care early and often will be beneficial and will increase awareness. Regarding the timeline of the study, the original plan was a 3-year project period, but they were probably overly optimistic. The silver lining is that there has been significant protocol development and work to obtain various scientific and administrative reviews through the IRBs and OMB. There has already been discussion about how to extend the project period of the study out longer than originally planned, and how to make the study sustainable over the long-term. Dr. Hennessy completely agreed that once the study was up and running, with all of the

resources dedicated to it, they should follow through for a lengthy period of time. He also agreed that the study is not holistic, which they have heard often when speaking with people on the Navajo Reservation. The struggle for epidemiologists is that they are taught not to try to assess all exposures and all outcomes, but instead to try to narrow their focus down to a one-to-one relationship. This is an inherent conflict with the scientific toolbox available to them.

- Mr. Jim stressed that the Navajo Nation appreciates any and all studies on risks associated with uranium mining. The Navajo Nation has put in a moratorium on uranium mining on any Navajo land within its jurisdiction, and is interested in all studies that associate any kind of diseases with uranium because they are going through Congress to look at amendments.
- Ms. Kaslow wondered whether they were embedding any mitigation measures to reduce exposure to pregnant women into the research design should they find that uranium exposure, whether naturally occurring or due to milling and mining, is a risk factor.
- Dr. Dearwent responded that there are mitigation measures included for some contaminants. Lead is a good example of having predefined actions that will occur should biomonitoring reveal lead levels above 10 micrograms per deciliter. Obviously, it is more important if they find an individual, especially a pregnant mother, who is in a less than safe environment based on environmental sampling. They will inject themselves to deal with this immediately. They will not turn a blind eye to this.
- Ms. Kaslow asked whether they had defined those protocols and shared them with the Navajo Nation and the University of New Mexico.
- Dr. Dearwent responded that they have done so. The University of New Mexico considered the lead protocol and have been developing their own protocol. There have been numerous meetings and discussions with the Navajo Nation IRB about this issue. This can be difficult because for some contaminants there are clear and stringent action, but for others there are not. Nevertheless, this has been a consistent point of discussion amongst all of the partners.
- Ms. Allison added that this study is part of a 5-year, 5-agency plan to assess and remediate uranium exposures on the Navajo Nation. Even as this study is on-going, the EPA has been working with the Navajo Nation's EPA to assess residential homes and buildings where they suspect that there might be contamination, specifically radon exposure. In some cases, homes have already either been remediated or completely demolished and new homes built. They have also been assessing a number of abandoned uranium mines on Navajo lands to determine where these are located and where the hot spots might be, and are then working to close those off and limit access to them. With the 5 agencies, there are several on-going activities.
- Mr. Antone noted that during the Summer 2010 consultation, this issue was one of the priorities that was discussed with Dr. Frieden.
- Dr. Dearwent said that while this was his first time attending one of these meetings, he thought they were actually on the cusp of starting what he calls the "real work."

#### **Office of Minority Health and Health Equity**

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

Mr. Taillepierre thanked Ms. Cantrell and Dr. Duckworth for giving him the opportunity to present a follow-up to the meeting in February to provide further information on the changes that have occurred within his office. One of these changes is that previously they were known as the Office of Minority Health and Health Disparities, but are now the Office of Minority Health and Health Equity (OMHHE) under Dr. Frieden in the OD. The new Director of OMHHE, Dr. Liburd, hopes that in the future she can also present directly to the TAC. OMHHE was formally registered about two weeks before this meeting, so they do not even have business cards. They are going through a strategic planning process that incorporates many of the activities he described during this session.

Health equity is included in the vision statement for CDC's vision for the 21<sup>st</sup> Century. This is the first time in CDC's history that they have incorporated the term "Health Equity" both in the vision and mission. OMHHE's mission has also changed. It is currently to accelerate the work of CDC and its partners to improve health by eliminating health disparities, promoting conditions conducive to health, and achieving health equity. This is the short version of the mission. In terms of the current strategic planning process, health equity is emphasized across all racial, ethnic, and other vulnerable populations. This includes people with disabilities; people with limited access due to language; and people who may be vulnerable because of issues of environment, behavior, or identity, including gay, lesbian, and bisexual populations. That is, they are not focusing solely on race and ethnicity in terms of the populations that are the focus of OMHHE's initiatives. Their definition of "health equity" is a direct quote from the health disparities report.

OMHHE is organized by some clear tenets in terms of a shared vision of collaboration and communication. One thing Mr. Taillepierre noticed as part of the discussion during this meeting was that OMHHE clearly needs to engage in more discussions with OSTLTS about how to communicate between the OMHHE office and OSTLTS, particularly since OMHHE is not focusing on specific initiatives for a particular population. All issues specific to a population, tribal communities for example, are going to be peppered throughout OMHHE's initiatives. Therefore, they want to ensure that they communicate this shared vision of collaboration and communication across leadership, science, partnerships, measures of accountability, workforce, and culture with OSTLTS and TAC. OMHHE looks forward to more discussion with OSTLTS and the TAC to ensure that there is good communication and collaboration.

Most of OMHHE's activities have been defined by the National Partnerships for Action (NPA). The mission of NPA is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action. The NPA has 5 goal areas that are coordinated through partnerships. Consequently, OMHHE organized its activities as part of its strategic direction under each of those goals. Some of the goals have a direct relationship with TAC, such as OMHHE's Health Disparities Course. OMHHE is assessing the types of courses CDC provides to its employees regarding health disparities and health equity. One issue regards how to create a better link between public health and population health so that issues of culture, context, and social determinants of health can be incorporated much more consistently across public health activities. Specifically, the NPA goals are as follows:

- **Awareness:** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.
- **Leadership:** Strengthen and broaden leadership for addressing health disparities at all levels.
- **Health System and Life Experience:** Improve health and healthcare outcomes for racial, ethnic, and underserved populations.
- **Cultural and Linguistic Competency:** Improve cultural and linguistic competency and the diversity of the health-related workforce.
- **Data, Research, and Evaluation:** Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

OMHHE is part of the Health Literacy Council within CDC, which is assessing how CDC creates public health communication strategies specific to distinct populations, how they are measured and monitored, and how to ensure that there is good public health communication between CDC and the nation. One question they are currently considering is: How does CDC know that populations across the country are actually receiving health messages, and what are the mechanisms for review and evaluation of those health communication strategies?

Mr. Taillepierre clarified that with the change of his office, the tribal grant awards were transferred to OSTLTS, but OMHHE is very interested in supporting TAC communication. OMHHE is still coordinating the CDC/ATSDR Minority Initiatives Coordinating Committee (CAMICC) and is in the process of enhancing its ability to collect information about minority initiatives and vulnerable population initiatives underway at CDC, and to determine how those initiatives are communicated internally at CDC across centers, institutes, and offices (CIOs) and to Dr. Frieden. These discussions need to be shared with TAC so that there is a clear point of communication and collaboration between TAC and CAMICC. CAMICC will continue its fundamental premise, which is to have a coordinated central mechanism for talking about minority health and vulnerable population initiatives at CDC. That will then be communicated through OSTLTS, hopefully to include ATSDR, and then it can be shared with TAC. All of those mechanisms for communication still have to be worked out.

OMHHE's new FOA was posted on March 25, 2011. Mr. Taillepierre hoped to be able to announce the grantees during this TAC meeting; however, there were some delays with PGO so he did not expect to be able to announce the grantees until later in the month. The components of the program FOA are multiple. There are three areas. Area A includes recruitment, orientation, placement, mentorship, and follow-up tracking of minority undergraduate students. Area B is the National Minority Undergraduate Student Coordination Center. Area C is the James A. Ferguson Emerging Infectious Disease Fellowship, which is a continuation of the previous James A. Ferguson program that was just re-competed.

Under Area A, grant recipients are to target up to 200 undergraduate students who have completed at least two years of accredited college study. This is a significant increase in the number of students to be targeted. This is a 10-week program, 2 weeks of which is administrative orientation by the grant recipient. This is followed by a 1-week orientation at CDC focused on public health. In the past, internship programs have emphasized key areas of

public health (e.g., epidemiology, surveillance, and statistics). The new initiative is much broader. The outcome of the internship is to have a better understanding of public health and to increase the number of students who are placed in health department and health centers throughout the US. Although up to 200 students may be recruited, only about 2% will be placed at CDC. The majority of students will be placed throughout the US, including its territories. The goal is for students to have a variety of experiences in terms of working in a public health setting. Program Area B, the National Minority Undergraduate Student Coordination Center, will assist CDC in better understanding the challenges for recruiting and retaining undergraduate minority students into public health. This program will collect information about these challenges, and will determine the best practices for addressing them. That information will be shared through CDC and its partners. Program Area C, the James A. Ferguson Emerging Infectious Disease Fellowship, will serve as a training site for 20 under-represented graduate students per year who self-identify within racial / ethnic minority populations. They will receive professional training placements in public health, academia, and similar settings in the US and its territories. That is an 8-week program with no orientation, given that most of these students are expected to have prior exposure to public health.

Mr. Taillepierre emphasized that OMHHE is very interested in not having a specific initiative for any one racial / ethnic population. They want to ensure, in a measurable way, that all of OMHHE's initiatives are reaching and addressing the issues that are raised by each racial ethnic population. OMHHE expects to provide regular updates in future TAC meetings regarding the status of its activities.

## **Presentations from Tribes Involved in the Traditional Foods Initiative**

### **Overview**

**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 thanked everyone for the opportunity to present on the Traditional Foods Initiative. During the February 2011 TAC meeting, he presented to the group. That was an opportunity to talk about the Traditional Foods Initiative formerly known as Using Traditional Foods and Sustainable Ecological Approaches for Diabetes Prevention and Health Promotion. For review, this is a cooperative agreement that is fielded out of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) through the Division of Diabetes (DDT) Translation. This initiative involves a cooperative agreement for 17 AI/AN partners across the nation for a 5-year cooperative agreement from 2008 through 2013 at \$100,000 per grantee per year. The approach to the Traditional Foods Initiative is that CDC did not superimpose a particular method, invited grantees to respond to a framework of using traditional foods, traditional forms of exercise, and traditional forms of social support for diabetes prevention and health promotion. The result is that they received a very eclectic group of proposals that are as diverse as the geographies each partner calls home. His presentation in February was just a shadow of what was going on because the most accurate presentation is for the grantees themselves to talk about their programs.

## **Salish Kootenai College**

**Jennifer Fowler**  
**Sandy Brown**

Ms. Fowler indicated that in terms of the foods they have gathered and dried, they begin with the spring. A major crop they gather is bitterroot, which is an important food for their people. They are seeding restoration plots to help elders remember gathering. Through this program, they are teaching the community, youth, and families how to gather and prepare traditional foods again. Every time a new plant is gathered during part of the season, they usually have a feast with it. They also engage in a number of native games, hiking, and conduct camps to get everyone outdoors and connected with nature again. Hunting and fishing are done during the fall to gather meat for the winter. During the winter, they engage in storytelling and other cultural activities such as dancing. Traditional foods are served throughout the seasons. Ms. Fowler shared a number of photographs to illustrate these activities. She began in the program as one of the five study families. Her children were overweight for their age, but through this program, her family became more active in the community and with the gathering of traditional foods. Today, they are living a healthier lifestyle and are healthy.

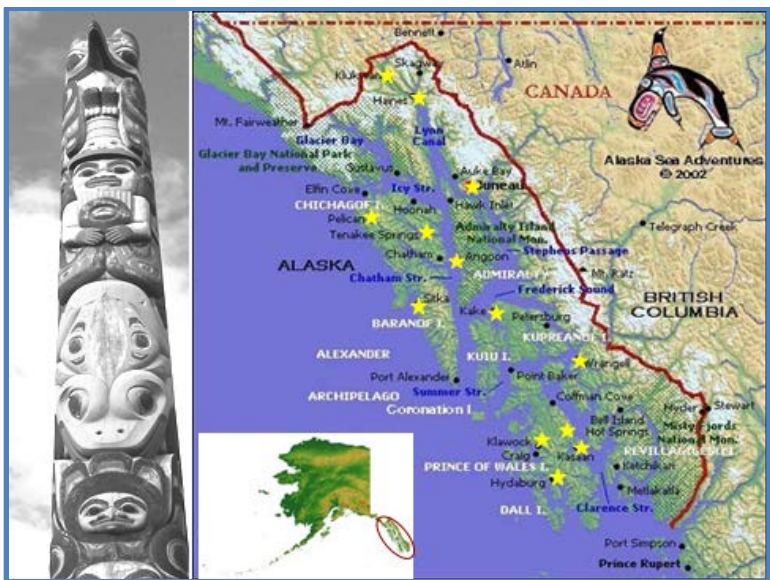
## **Southeast Alaska Regional Healthcare Consortium**

**Martha Pearson, MA, ACSM**  
**WISEWOMAN Women's Health Program Coordinator**  
**South East Alaska Regional Healthcare Consortium**

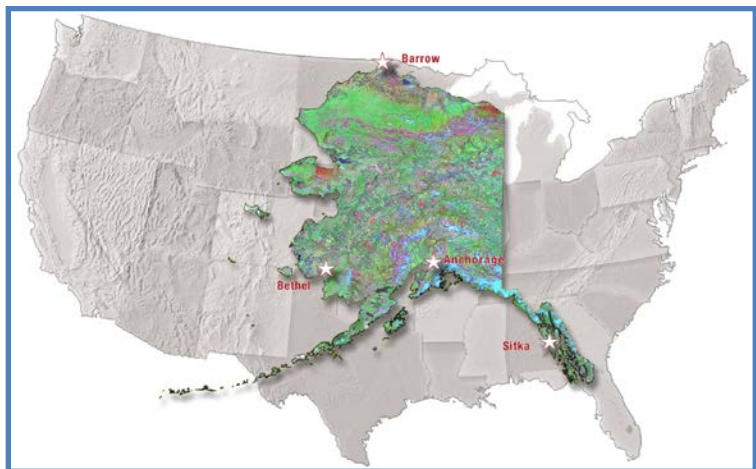
Ms. Pearson, Program Coordinator for the South East Alaska Regional Healthcare Consortium (SEARHC), shared information about SEARHC's traditional foods grant programs. She acknowledged that SEARHC is a grateful recipient of several CDC grants, including the WISEWOMEN Women's Health Program, National Breast and Cervical Early Detection Program, diabetes and tobacco programming, and colorectal cancer screening.

SEARHC's traditional foods program has adopted the nickname Tsu Heidei, which is from a Tlingit song and roughly translated means, "We will again open this container of wisdom that has been left in our care." This is the theme of SEARHC's programming. SEARHC is a PL 93-638 tribal organization that was established in 1975 by the Tlingit, Haida, and Tsimpshian tribes. It is tribally governed by an 18-member Board of Directors representing the 18 communities for which SEARHC receives IHS compact funds. There are 1,000 employees and 330 HRSA clinics. All of SEARHC's clinics are HRSA sliding fee scale clinics, except those in Juneau and Sitka. SEARHC serves 12,500 beneficiaries and another 6,000 non-Native beneficiaries in rural areas where access to health services is minimal. SEARHC is one of the oldest and largest 638 contractors in the country. The 18 communities served are located along the archipelago of Southeast Alaska, which is a 300-mile area roughly the size of Florida. Most of the area is not connected by roads, so everyone must travel by boats and planes most of the time. The gold stars on the following map show where the clinics are located:





There are 10 community health clinics, one homeless clinic, and clinics in Sitka and Juno, which are the largest clinics. SEARHC is located halfway between Seattle and Anchorage. Their primary communities focused on the Traditional Foods Grant funding are Wrangell (population ~2000) and Kake (population ~500). They are also able to engage in traditional foods work in some other communities through partnerships. Alaska is the most sparsely populated state with just under 700,000 people, half of whom live in Anchorage. There are more than 200 recognized tribes in Alaska. Alaska is extremely large as illustrated by the following overlay:



Alaska is remote and beautiful, and is deeply linked to the cultural values of the Native people. They are fortunate in their natural setting to have local healthy foods such as salmon and other seafood, berries and greens that are still available to harvest, and small communities that are strongly intertwined. However, they are challenged by difficult weather, high cost and low quality of shipped in foods, high rates of historical trauma and domestic violence, and small communities that are strongly intertwined. All of this blends together to create the context in which the traditional foods camps occur.

Diabetes is a serious and rapidly growing health problem among Native people. Alaska has the highest rate of increase in diabetes prevalence of any of the IHS areas. In 2006, an estimated 52 out of every 1,000 Southeast Alaska Natives had diabetes. The high prevalence and burden of disease within Native communities often leaves people with a sense of inevitability that "all my relatives have diabetes, so I probably will too." People feel overwhelmed by the recommendations for exercise, diet, and body images promoted in the media and lack the support necessary to make difficult lifestyle changes [FY97-02 IHS APC files. Excludes data from 38 service units (5% of service population; SEARHC RPMS Diabetes Registry, 2008; Alaska Area Diabetes Program. Age-adjusted using US 2000 standard population].

However, they have the power to combat diabetes and it is important to remind their people that they can take steps toward a positive future for themselves and their loved ones. They are fortunate to be surrounded by foods that prevent diabetes. In a study published just this spring, Zeina Makhoul, Ph.D., a postdoctoral researcher in the Cancer Prevention Program of the Public Health Sciences Division at the Hutchinson Center, said that, "It appeared that high intakes of Omega-3-rich seafood protected Yup'ik Eskimos from some of the harmful effects of obesity" and that "While genetic, lifestyle, and dietary factors may account for this difference, it is reasonable to ask, based on our findings, whether the lower prevalence of diabetes in this population might be attributed, at least in part, to their high consumption of Omega-3-rich fish" [March 23, 2011 in the European Journal of Clinical Nutrition]. This is good and exciting news. They also have the strength of the Native people in the region who have lived in Alaska for more than 10,000 years.

SEARHC funding for the Traditional Foods grant is used to support traditional culture camps in the villages of Kake and Wrangell. The Traditional Camp philosophy is that to know complete wellness, one must be healthy in mind, body, and spirit. There is one person who is the lead coordinator in each community. This person is paid by grant funds to facilitate community wishes and implement programs. The grant funds also pay for supplies and travel as needed. Ms. Pearson showed a short clip that the SEARHC staff created to describe how the program works. Each funded community has one paid staff member and an advisory board that makes recommendations on timing and efforts. SEARHC depends heavily upon local volunteers and helpers not to act as teachers and guides, but to bring their family members and community members to the events. Due to the limited nature of the funding, their ownership is crucial as they play major parts in implementing the activities. Mini-camps engage youth and adults and topics include traditional foods, storytelling, drumming, singing, or crafts. Elders advise and participate. SEARHC does its best to build on existing culture camps, community gardens, and efforts that are already in progress but could use a boost from SEARHC funds and advising. Ms. Pearson shared photographs of seaweed gathering and a deer butchering demonstration, which was done in partnership with the public schools.

SEARHC is very flexible in its programming to take advantage of the seasons and the opportunities as they present themselves. Ms. Pearson emphasized how this flexibility allows them to be more successful. None of this work is done in isolation. For example, this summer they were dealing with paralytic shellfish poisoning in the State of Alaska. Some of the camps had the habit of going out and gathering shellfish as a matter of course and teaching students how to shuck the clams, can them, and prepare them for eating. Local culture camps worked with SEARHC and its partner Cooperative Extension to ensure that no clams or other shellfish were harvested that could be poisonous. SEARHC was also poised to partner with the camps and build capacity for using pressure canners for food preservation instead of water baths. In this way, CDC funds are used to ensure food security as well as nutrition.

Another objective that SEARHC is able to allocate resources toward is digital storytelling. The grant application asked them to engage in storytelling, and SEARHC decided to take it one step forward to propose digital stories. Digital storytelling blends storytelling traditions with computer-based technology as a way for people to be able to tell their own story using free multimedia tools. Through the use of digital storytelling technology, people are empowered to share a meaningful, heart-felt message, and are moved from being passive recipients of health messages to actively creating a way to have their voice enter the conversation to make a difference in the story of wellness for the Native Peoples of Alaska. Ms. Pearson shared one of the digital stories.

In summary, SEARHC knows that certain things work well in its small communities. With all due respect and gratitude for its funders, they really could not do all of this with just the funds that are given to them. They can do a lot more of the work with their ability to partner. They have the flexibility to work with communities and dovetail with their priorities, while staying within guidelines of physical activity, traditional foods, and storytelling. With this model, it is wonderful to see how a little bit of money can really go far. It also tells them that it really takes local knowledge to make primary prevention work on this level, because they must have local engagement. Ms. Pearson emphasized that it is important to know what is going on in the community with respect to factors that might work for or against programming efforts.

There are some challenges. While the camps practice safety measures, there is always going to be risk involved with boating, digging, and cutting. All community members are not appropriate as leaders, so there is a political landscape to deal with. They jokingly refer to STP, which means "same ten people" show up and help each time, so they have to work really hard to engage more than the STP. Evaluation is a joy and a challenge, because it is difficult to determine whether SEARHC's activity caused the healthy behavior change. The primary evaluation tool is the HHS waiver that each participant in a camp must sign. SEARHC had the idea that as long as participants were signing a piece of paper to participate in a camp, some of their baseline fruit and vegetable intake and physical activity minutes per day could be captured. BRFSS questions were selected to acquire this information.

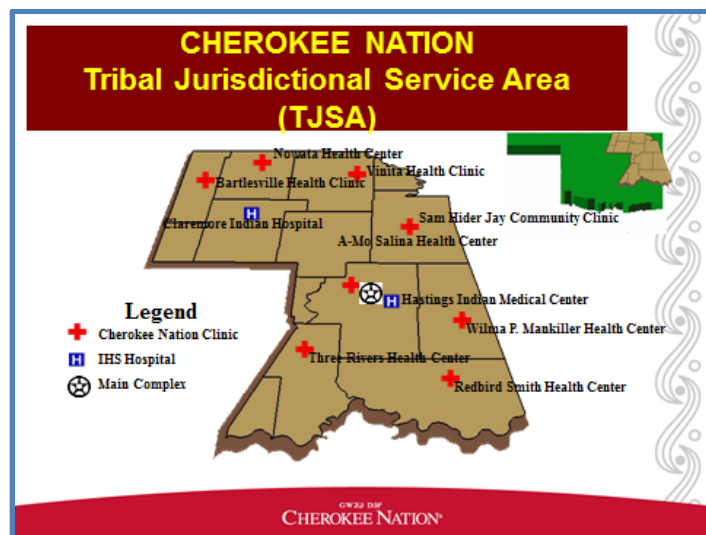
Preliminary evaluation data comparing year two responses to year three show an increase in fruit consumption by 1.125 cups per week, an increase in vegetables by .5 cups per week, and an increase of 32 minutes per day on days when the person is moderately active. The N for these comparisons is not large enough to make rousing success statements, but SEARHC was happy to see these results. With these evaluations completed by camp participants this year and for the next two years, they hope to see solid trends. Other outcomes have included some good policy changes at the local level. Bartering lines have been re-established through SEARHC's Facebook page and through our other connections, so people are trading with other communities outside of their family members. Seven communities are actively swapping seaweed for herring eggs to share foods that are not locally available. SEARHC's Facebook page works well to link program activities with similar efforts in the region, show off pictures and videos, share recipes, and connect people who want to trade foods. The slogan of the program is the Tlingit phrase Yeh naa teech (head thrown back) meaning "it doesn't get any better."

### **Cherokee Nation**

**Julie Kimble, MS**  
**Primary Prevention Project Specialist**  
**Cherokee Nation, Healthy Nation**

Ms. Kimble, program manager for the Traditional Foods Grant, thanked CDC and TAC for the opportunity to talk about the Cherokee Nation Traditional Foods Project. She also recognized Cora Flute, the Public Health Educator for the project, who is a very important part of this grant and the initiatives. She also expressed great appreciation for Commander Alonso. Ms. Kimble explained that Cherokee Nation is located in North East Oklahoma, near Tulsa. They are the second largest tribe in the nation, serving a 14-county jurisdictional area that covers 7,000 miles. Their main headquarters are in Tahlequah, which is her jobsite. They serve the entire community, not just a reservation.

The following map reflects the Cherokee Nation's health facilities and jurisdictional area:



There are two Public Health Educators at each of the clinics, as well as two in Tahlequah. The Public Health Educators are very important because they are really the hands and feet of the program, given that they work directly with the community.

What constitutes a Cherokee traditional food depends upon who is asked in terms of the generation in which they group up and their living environment. They try not to be the traditional food police, but instead encourage them to eat healthier traditional foods. Healthy Nation, sometimes referred to as community health promotion and prevention, is under the umbrella of Cherokee Nation Health Services. They are very lucky and fortunate to have a Chief and leadership of Cherokee Nation that supports their efforts in prevention. This began with a Robert Wood Johnson (RWJ) grant 17 years ago with the Director of their program, Lisa Pivec.

Healthy Nation's services focus on the three areas of physical activity programs and policy development, nutrition programs and policy development, and tobacco cessation and policy development. One component of Healthy Nation's Traditional Foods Work Plan is community gardens. They identified the communities they fund through the Principal Chief's Community Health Leadership Award, which is a short RFA for which communities apply. They can apply to engage in activities that increase access to healthy foods in their communities. A very strong aspect of Healthy Nation's program is its partnerships with other Cherokee Nation departments such as Community Services, Natural Resources, and the Cultural Center. Ms. Kimble shared photographs of the Muldrow Cherokee Community Organization Youth Garden, which includes gardens for youth and adults; Blue Sky Water Community Garden, Sparrow Hawk Community

Garden Signage, and Oaks Indian Mission School. To date, three Tribal Worksite Gardens have been established, including Jack Brown Center (rehabilitation center/school), Job Corps Center (also student based and is residential), and Male Seminary Recreation Center Campus (includes contract health, WIC, Healthy Nation, et cetera). These sites were selected based on having easy access to water and land, and are part of the Worksite Wellness Program for which there are offices throughout the 14 counties.

School-Based Community Gardens have also been established and are very popular. These are promoted through the Principle Chief's School Health Leadership Award. This provides gardening and skills-building training. There is also a partnership with Cherokee Nation Education Services, Kerr Center for Sustainable Agriculture Farm to School Program. Healthy Nation does actually implement these gardens. They provide technical assistance in terms of helping to create a plan for the garden, and the school, community, and tribal worksites take ownership of the gardens.

Another component of the program is community education classes, which include gathering trips, canning and preservation, and traditional food preparation. Gathering trips are very popular, and they are very careful not to disturb the land of the Cherokee communities. The program also creates educational materials. They develop one item per year, and have completed three so far. They compile information, work with community gardens to develop the materials, and provide materials to communities. For this, they are partnering with Cherokee Nation Cultural Center, Community Services and Communications. Ms. Kimble shared samples, including Marble and Kanuchi "How-to" books for the community to be useful for teaching/learning and passing down to Cherokee children and youth. One book is about how to make Kanuchi from the hickory nut. It goes through the whole process from gathering the hickory nut, to drying it, to pounding it to get a Kanuchi ball. The other is on Cherokee marbles.

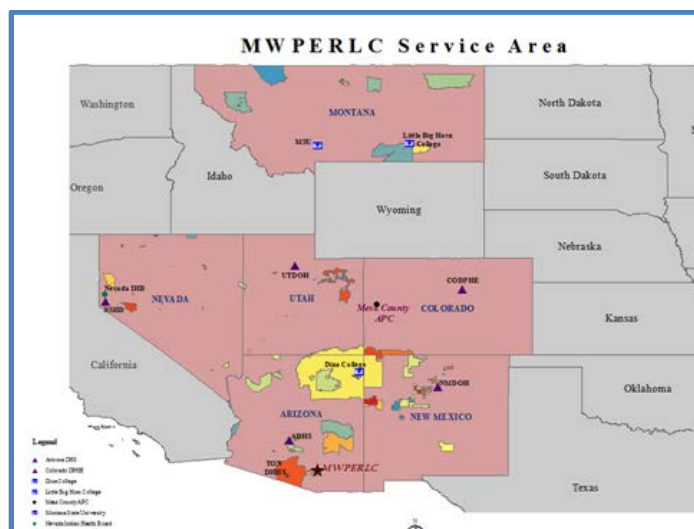
Traditional games are very popular, especially stickball. They have Cherokee stickball and marble leagues. They are supposed to do two per year, but do much more than that because it is fun. There are school-based and community-based traditional games. If a school is interested in doing more traditional games at their school, they can apply for that through the school and the Community Health Leadership Award so that Cherokee Nation can help them with getting sticks, balls, and equipment to play stickball. Ms. Kimble shared a photograph of Commander Alonso playing stickball. They also have a radio station called "Radio Voices," for which Dennis Sixkiller does the radio program. He is also an avid marble player, so he teaches marbles. Cherokee Nation attempts to address policy systems and environmental change across the board with its programs. They support the "Buy Fresh Buy Local" promotion, are working on policy development in the farm to school program, and partners with Cherokee Nation Commerce Department, Career Services, Kerr Center, and Cherokee County Health Coalition.

## **Building Tribal Community Resilience**

**Brenda Granillo, MS, Director  
Mountain West Preparedness and Emergency Response Learning Center**

Ms. Granillo, Director of Mountain West Preparedness and Emergency Response Learning Center (MWPERLC), explained that MWPERLC is a network of four Learning Centers serving the public health preparedness training needs of the US public health workforce. This center is

located at the University of Arizona in Tucson. The learning centers serve in a national capacity for preparedness and response training and work with state, local, and tribal public health partners for workforce development. In 2005, MWPERLC covered only Arizona, but with a new cooperative agreement that was funded in August, they had to expand their service area. MWPERLC now covers four corner states, Nevada, and the tribes of Montana through a cooperative agreement with Montana State University and Little Big Horn College. The service area is depicted in the following graphic:



Within the MWPERLC service area region, there are about 81 federally recognized tribes, and there is a very strong focus on tribal public health preparedness. MWPERLC's reach is large. Some of the partnerships that they have worked with since 2005 include the following:

- Diné Community College (Navajo Nation)
- Divisions of Health: Navajo and Tohono O'odham Nation
- Indian Health Boards: Nevada and Albuquerque
- Indian Health Service: Navajo, Phoenix, and Tucson Area
- Inter Tribal Council of Arizona, Inc.
- Little Big Horn Community College (Crow Nation)
- Southern Ute Indian Tribe
- State Health Department Tribal Liaisons
- Ute Mountain Ute Tribe

The MWPERLC works with key tribal representatives throughout the service area to provide oversight for tribal training programs. A Tribal Advisory Board was established in April 2011. The role of the board is to ensure that: 1) Training programs are culturally appropriate and respect sovereignty; 2) Tribal preparedness and response training needs are addressed and prioritized; Tribal Subject Matter Experts are identified to assist in the design and provision of training; 4) The method of delivery for training programs maximizes reach and participation; and 5) MWPERLC tribal initiatives support a national framework applicable to tribes across the country.

There are a number of challenges with respect to tribal public health emergency preparedness. There seems to be a gap between capability and capacity. The new CDC cooperative agreement for the program is built on capabilities. It is known that responses start and end



locally. For most rural tribal partners, it will probably be 42 hours or beyond before any outside assistance arrives. Many tribes are located in remote and rural areas, making communications and timely transportation difficult. Many tribes cross multiple jurisdictions, states, and international boundaries. Each tribe has unique cultural practices and spoken dialect, and resources are scarce.

A number of recommendations came out of the Tribal Advisory Board Meeting held in April 2011, including entry level competency-based training; a strong need to build local capacity by providing training opportunities in community preparedness and recovery (e.g., community resiliency); and a need for public health emergency preparedness training for tribal leadership. The mandate for the new MWPERLC program is to develop competency-based training, but for the Tier II workforce. Tier II is defined as mid-level, 5 to 10 years of experience in the field. Tribal members are continually saying that they need Tier I training, but MWPERLC is not at the point to be able to do Tier II. They spoke with their Project Officers, and even though legislation requires that they develop Tier II training, they still deliver Tier I training. They have over 25 online competency-based training programs for Tier I. Again, they heard a strong need from tribes that they need to build local capacity.

Based on those recommendations, MWPERLC contemplated how to build a community resiliency framework post-disaster. They have been working the last 4 to 5 months, meeting with our tribal partners in our service area, to try to understand what this would look like. Currently, this includes four phases, which are as follows:

- PHASE I: Identifying Tribal Readiness
- PHASE II: Assessment of Community Resiliency Plans and Procedures
- PHASE III: Inventory of Community Assets, Skills, Capabilities, and Resources
- PHASE IV: Training and Exercising the Community

During Phase I, they will implement two methods for quantitative and qualitative data. RAND has an initial assessment tool that will be used to assess community wellness. This will be coupled with data collected from tribal leadership training to achieve buy-in. MWPERLC realizes that some tribes may already be beyond this phase, so they can go straight into Phase II. If a tribe is ready, willing, and able, they will be provided with tools, resources, and technical assistance to develop community resiliency plans. MWPERLC is developing four competency-based online training courses, including: Community Preparedness, Community Recovery, Special Populations, and Behavioral and Disaster Mental Health. During Phase III, an inventory of community assets will be compiled by populating a database of community assets (e.g., skills, capabilities, and resources). Several vendors offer software capable of collecting these data, with varying costs. Phase IV will consist of training, testing, and practicing emergency response plans. This can be done through workshops, courses, and just-in-time training (JITT). These are just a few examples of training approaches designed to better prepare participants to perform in exercises. During this phase, they will also evaluate the extent to which training transfers to exercises. This will be done through two approaches, which are to employ a longitudinal approach which tracks individuals from training to exercises; and assess the extent to which EOPs and SOPs change over time as a result of training.

While this will require significant resources, there are funding challenges. MWPERLC received a 40% reduction in its overall budget for 2011 that was not expected. They were given a 5-year cooperative agreement, so this came as somewhat of a surprise. The PERLC program has also been zeroed out for the 2012 budget. While they are hoping that it will be restored, this remains

unknown. Meanwhile, they must find alternative funding mechanisms to support tribal initiatives in public health emergency preparedness. With the community resiliency framework, MWPERLC is trying to build something that is sustainable and in which the tribes have ownership. The only way it is going to be sustainable is with buy-in from leadership, with the programs running at the tribal community level.

In conclusion, Ms. Kimble shared her contact information and invited feedback from the TAC membership. She also encouraged them to go online to take some of MWPERLC's competency-based training in emergency preparedness:

Brenda Granillo, MS, Director  
Mountain West Preparedness and Emergency Response Learning Center (MWPERLC)  
University of Arizona  
Phone: (520) 626-0617  
Email: [bgranill@email.arizona.edu](mailto:bgranill@email.arizona.edu)  
Website: <http://www.mwperlc.arizona.edu/>  
Training Portal: <http://lms.mwperlc.arizona.edu/>

## Preparedness

**Gregory A. Smith, Tribal Liaison Officer**  
**Program Services Branch**  
**Division of State and Local Readiness**  
**Office of Public Health Preparedness and Response**  
**Centers for Disease Control and Prevention**

Mr. Smith noted that he was the former Project Officer for the Region 8 states and covered Montana, Wyoming, North Dakota, and South Dakota. Before coming to the Public Health Emergency Preparedness (PHEP) program, he was the Project Officer for several states, including 10 states and 4 community-based organizations (CBOs) spanning from Missouri to Washington and California. About 5 years ago, he came to the PHEP program and was assigned a project to work with the states directly to focus on preparedness, and preparedness criteria and activities in terms of what could be done to make the country more focused in preparedness and to assist them in moving through a potential catastrophe or disaster. Now assigned as the new Tribal Liaison Officer from the Program Services Branch of DSLR, he will be the contact, working in conjunction with OSTLS, to produce programs focused directly toward tribal capabilities. There are 15 capabilities and sub-criteria which they would like tribes and the entire country to meet. There are some issues with respect to crossing state lines, international borders, cities, counties, et cetera. However, they hope to overcome some of these issues by the Program Services Branch, OSTLTS, and the rest of CDC programs working together to ensure sufficient capabilities. Mr. Smith indicated that the Program Services Branch is in the process of developing a framework for community preparedness for tribes. He is assigned to author this framework as much as possible. He invited everyone to contact him with questions and input to ensure a positive outcome in terms of community preparedness in the tribal lands.



## Closing Remarks / Blessing

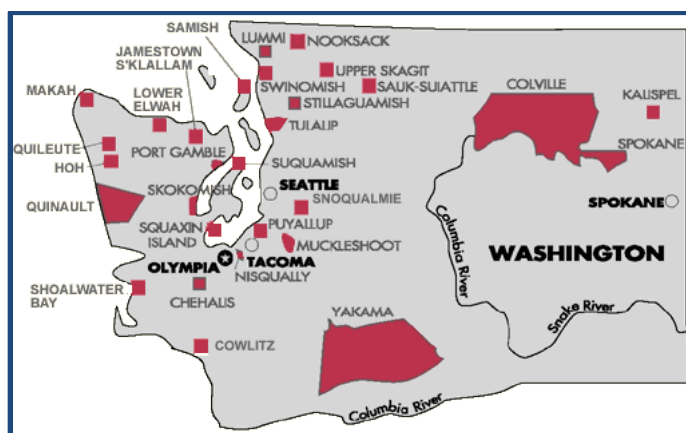
Dr. Holzman thanked everyone for their great work, assuring them that they would continue these conversations moving forward.

Ms. Nielson reminded everyone to meet in the lobby in the morning at 7:30 am, noting that the bus would be departing at 8:00 am, with plans to arrive at Jamestown S'Klallam Tribe by 9:15 am.

Mr. Antone officially adjourned the meeting for the day with a closing prayer.

## Site Visits

During the second day of the TAC meeting, participants made site visits to Jamestown S'Klallam and the Makah Reservation. The site visits were arranged and orchestrated by the Northwest Portland Area Indian Health Board, the host for the August 2011 TAC meeting. Participants boarded a bus together early on the morning of August 23, 2011. Joining them was a tribal elder who spoke about the Jamestown S'Klallam development and campus. The Jamestown Reservation is located in Western Washington on 20 acres along the Southern shores of the Strait of Juan de Fuca. The Jamestown S'Klallam Tribe is also known as "The Strong People." Jamestown S'Klallam is an amazing and beautiful facility that is comprised of Cedar Boughs Art Gallery, the Smoke Shop, and 7 Cedars Casino. During this segment of the trip, participants were able to visit the gift shop, which carries coastal Northwest art, and had breakfast in the nearby 7 Cedars Casino. The following map shows the location of the Jamestown S'Klallam Tribe and its relationship to the Makah Reservation and the remainder of the state:



[[http://www.npaihb.org/member\\_tribes/washington\\_member\\_tribes/](http://www.npaihb.org/member_tribes/washington_member_tribes/)]

The next segment of the journey took participants to the Makah Indian Reservation, which is located on the most Northwestern tip of the Olympic Peninsula in Clallam County, Washington. The reservation is bound in the North by the Strait of Juan de Fuca, while the Western boundary is the Pacific Ocean. The name "Makah," given to this tribe by neighboring tribes, means "Generous with food." The Makah Tribe was, indeed, very gracious about having the group tour their village. After being served a lovely traditional salmon dinner, complete with traditional dancing and drumming, the group toured the Makah Indian Reservation's amazing and beautiful

museum, Makah Cultural and Research Center, in the fishing village of Neah Bay—the largest community of the Makah Indian Reservation. They then returned to the community center for a tribal meeting with the elders and the tribal council. The following map and legend offer a visual of the area:



**LEGEND**

	Freeways/Highways/paved roads open to visitors		Road to Ozette Archaeological Site
	Gravel road open to visitors		Gravel/earth roads open to visitors
	Ferry Routes		Areas/Beaches open to visitors
	Areas/Beaches closed to visitors		Ozette Archaeological Site
	Makah Museum		Cape Flattery Viewpoint
	Neah Bay		Hobuck Beach Campground
	Koitiah Viewpoint		Hobuck Beach
			Makah Nation Fish Hatchery

[<http://www.northolympic.com/makah/map.html>]

## **Attendant Roster**

### **Tribal Advisory Committee (TAC) Members**

Chester Antone, Tohono O'odham Nation  
Jay C. Butler, MD, Alaska Native Tribal Health Consortium  
Karen Hearon, Tribal Self-Governance Committee  
Connie Hilbert, MS, RS, Mohegan Tribe  
Rex Lee Jim, Navajo Nation  
Jackie Kaslow, California Area Representative  
Sherrilla McKinley, Inter Tribal Council of Arizona, Inc.  
Brenda Nielson, NPAIHB Quileute Tribe  
JT Petherick, JD, MPH, Muscogee (Creek) / Cherokee  
Marlene Redneck, Direct Services Tribe  
Alicia Reft, Karluk Ira Tribal Council  
Tihtiyas (Dee) Sabattus, United South and Eastern Tribes, Inc.  
Lester Secataro, Albuquerque Area Indian Health Board  
Derek C. Valdo, Pueblo of Acoma Tribal Council

### **Other Tribal Organizations / Tribal Health Boards / Tribal Health Professionals**

Julie Kimble, MS, Cherokee Nation  
Martha Pearson, MA, ACSM, South East Alaska Regional Healthcare Consortium  
Mike Tryon, Salish Kootenai College

### **Centers for Disease Control and Prevention**

Annabelle M. Allison, National Center for Environmental Health / Agency for Toxic Substances and Disease Registry  
Ursula Bauer, PhD, MPH, National Center for chronic Disease Prevention and Health Promotion  
Kimberly Cantrell, Office for State, Tribal, Local, and Territorial Support  
Steve Dearwent, MPH, PhD, National Center for Environmental Health / Agency for Toxic Substances and Disease Registry  
Kathleen A. Ethier, PhD, Office of the Director  
Tom Hennessy, MD, MPH, Artic Investigations Program  
Gregory S. Holzman, MD, MPH, Office for State, Tribal, Local, and Territorial Support  
Eva Margolies, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention  
Gregory A. Smith, Office of Public Health Preparedness and Response  
Arjun Srionivasan, MD, Healthcare Associated Infection Prevention Programs

### **Other Guests**

Brenda Granillo, MS, Mountain West Preparedness and Emergency Response Learning Center, University of Arizona  
Amy Johnson, Cambridge Communications

## Appendix: Official Area Reports Submitted

### CDC Tribal Advisory Committee (TAC) Biannual TCAC Member Report Summer 2011

TAC Member: Lester Secatero

Area or National Organization: Albuquerque Area

Timeframe: March-September

- **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?** The information has been disseminated through monthly Albuquerque Area Indian Health Board and To'hajiilee Health Board meetings.

- **Whom have you communicated with?**

Area Indian Health Board

Tribal Organizations

Tribal Consortia

Tribal Leaders

Other \_\_\_\_\_

- **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 TAC?**

- Diabetes
- Cancer
- Behavioral Health\*
- Dental
- Heart Disease
- Injury Prevention



\*Includes substance abuse, suicide prevention, and depression.

- **Please highlight some public health activities being planned or implemented in your Area?**
  - March 4—Albuquerque Area Southwest Tribal Epidemiology Program Quarterly meeting
  - March 22-23—Wind River, WY Tribal Colorectal Health Workshop
  - April 11-12—Oklahoma Area Tribal Colorectal Health Workshop

- April 14—Alamo Navajo Health Fair
  - April 18-21—2011 Circle of Harmony HIV/AIDS Wellness Conference, Hard Rock Hotel and Casino, Albuquerque, NM
  - May 12—Colorectal Health Task Force meeting, Alamo Navajo
  - May/June—Colorectal Health Task Force meetings, Ute Mountain Ute, Jicarilla Apache, To'Hajiilee Navajo, and Mescalero Apache
  - June 7-9—Billings Area Tribal Colorectal Health Workshop
  - June 17—Tesuque Pueblo Health Fair
  - June 24—Albuquerque Area Southwest Tribal Epidemiology Program Quarterly meeting
  - July 13—Mescalero Apache Health Fair
  - July 21—Ramah Navajo Health Fair
  - August/September—Navajo Nation Tribal Colorectal health workshop
  - August 23-26—Colorectal health digital storytelling workshop for Community Health Representatives
  - Monthly AAIB Board of Directors' meetings
- **What additional issues do you think that CDC and the TAC should be aware of it as they relate to American Indian/Alaska Native people and communities?**

There are too many tribal consultation meeting requests—needs to be streamlining and with feedback on the implementation of recommendations. The Federal agencies should work together to schedule consultation meetings.

It is difficult to reach people at the CDC as a tribal leader. Recommend a tribal liaison for tribal leaders to contact.

- **What additional information would you like from CDC?**

Emergency preparedness information for Tribes

**CDC Tribal Advisory Committee (TAC)  
Biannual TCAC Member Report  
Summer 2011**

**TAC Member: Alicia Reft/Jay Butler**

**Area or National Organization: Karluk Tribal Council/Alaska Native Tribal Health Consortium**

**Timeframe: Feb –Aug 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?**

To some degree—there has been a limited amount of information to share to date. Much of the discussion in the February 2011 TAC was procedural. Jay Butler does now have a regular spot on the Alaska Native Tribal Health Consortium Board (ANTHC) agenda and will use that time to provide an update from the CDC.

**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 TAC?**

From the ANTHC Board Retreat, Aug 8-9, 2011:

- Suicide
- Cancer
- Unintentional injuries
- Diabetes and other complications of obesity
- Oral health
- Alcohol abuse
- Tobacco
- STIs

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

(Very broad question—sort of like asking “What does CDC do?”)

Alaska has 3 colorectal cancer screening grants—one to SouthCentral Foundation, one to Arctic Slope Native Association, on to ANTHC. The ANTHC grant provides screening colonoscopy to persons aged 50 to 80 and to first degree relatives of persons with colorectal cancer. In FY 2011, over 300 persons have been screened through the grant to ANTHC.

Completing first year of National Public Health Improvement Initiative grant to ANTHC. Performance Improvement Manager (PIM) hired and initial focus has been on organizational strategic alignment, on identifying metrics for assessing performance, on evaluation of public health accreditation in the Alaska Tribal Health System, and on applying Lean Six-Sigma to improving efficiency and effectiveness in the ANTHC Tobacco Cessation Program. The PIM and PI of the grant are obtaining Green Belt certification has part of this process.

In partnership with the State of Alaska Division of Public Health and Providence Alaska Health Systems, ANTHC applied for a Community Transformation Grant.

**What additional issues do you think that CDC and the TAC should be aware of it as they relate to American Indian/Alaska Native people and communities?**

Six Winnable Battles are not entirely aligned with priorities reflected by the data on health status in Indian Country.

There has been little apparent benefit from Public Health Accreditation.

**What additional information would you like from CDC?**

More timely updates, along that lines of what State Health Officials receive through ASTHO and State Epidemiologists receive through CSTE.

**CDC Tribal Advisory Committee (TAC)  
Biannual TCAC Member Report  
Summer 2011**

**TAC Member:** Marlene Redneck

**Area or National Organization:** Direct Service Tribes Advisory Committee (DSTAC)

**Timeframe:** Summer 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?**

Limited information has been disseminated to the DSTAC over the last few months.

- **Whom have you communicated with?**

Area Indian Health Board

Tribal Organizations

Tribal Consortia

Tribal Leaders

Other \_\_\_\_\_

- **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 TAC?**

The DSTAC has identified the following health issues as their priorities for FY 2012:

1. Diabetes
2. Behavioral Health / Mental Health
3. Cancer
4. Heart Disease
5. Health Promotion / Disease Prevention
6. Alcohol / Substance Abuse
7. Dental
8. Injury Prevention
9. Maternal / Child Health
10. Water Sanitation

- **Please highlight some public health activities being planned or implemented in your Area?**

The DSTAC is currently holding the 8<sup>th</sup> Annual National Meeting to provide a forum for direct service tribal leaders to discuss issues of concern and receive information and update on programs administered by the Indian Health Service.

- **What additional issues do you think that CDC and the TAC should be aware of it as they relate to American Indian/Alaska Native people and communities?**



The DSTAC supports partnerships between DHHS agencies and encourages broad information dissemination to reach all federal and tribal programs.

- **What additional information would you like from CDC?**

Information on resources available to both federal and tribal health programs and facilities.

**CDC Tribal Advisory Committee (TAC)  
Biannual TCAC Member Report  
Summer 2011**

**TAC Member: Dee Sabattus, Nashville Area Alternate  
Area or National Organization: United South and Eastern Tribes, Inc. (USET)  
Timeframe: FY 2010-2011**

**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?**

Yes, USET has disseminated and shared information 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).

**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. 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 TAC?**

Tribes within the Nashville Area have identified the following areas for topics of discussion with TCAC: Pre-diabetes, Obesity, Prescription Drug Abuse and the disposal of unused meds.

**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:

- Local Health Needs Assessments
- Community Health Profiles
- Diabetes
- White House Prescription Drug Initiative
- 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).
- Supporting IHS National Immunization Reporting System whereby tribal specific childhood immunization coverage surveillance data is maintained and quarterly reports distributed to Tribal health officials. USET is also assisting Tribes with establishing relationships with State Immunization Registries and initiating a Tribal/State Immunization Interface.
- Conducting tribal specific oral health surveys, and assisting IHS adopt our methodology for use in other IHS areas.

**What additional issues do you think that CDC and the TAC should be aware of it as they relate to American Indian/Alaska Native people and communities?**

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

**What additional information would you like from CDC?**

- 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.
- USET request that the CDC initiate a long term, federally funded program to generate adequate financial and technical support so that every five years each federally recognized Tribe in partnership with its region's Tribal Epidemiology Center is able to implement Tribal specific Behavioral Risk Factor Surveillance System (BRFSS) data collections to evaluate community health risk factors. This would generate Tribal specific BRFSS data that is compatible with state and national BRFSS data for useful epidemiological comparisons and priority setting.
- USET request 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 21<sup>st</sup> 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.

**CDC Tribal Advisory Committee (TAC)  
Biannual TCAC Member Report  
Summer 2011**

**TAC Member: Derek Valdo**

**Area or National Organization: National Congress of American Indians**

**Timeframe: January 2011 thru July 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 consistently disseminates and shares information about CDC to our member Tribes and delegates via various multi-media.

**Whom have you communicated with?**

- Area Indian Health Board Tribal Organizations
- Tribal Consortiums Tribal Leaders
- Other

**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 TAC?**

Nationally, NCAI strives to protect Indian Country from budget cuts. An overwhelming majority of federal funding comes from the discretionary portion of the budget. Tribes have suffered from inadequate funding for years and any cuts impact services to their communities.

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

NCAI's Annual Meeting and Convention will be hosted Oct. 31 – Nov. 4 in Portland, OR. Our Health and Human Services Committee will convene to discuss public health issues throughout Indian country.

**What additional issues do you think that CDC and the TAC should be aware of it as they relate to American Indian/Alaska Native people and communities?**

NCAI would like to see the performance improvement in Tribal communities as it relates to the winnable battles. NCAI also strongly supports Native American preference in the hiring of the Tribal Affairs Director.

**What additional information would you like from CDC?**

Marketing material of the CDC Tribal Resource website for dissemination at NCAI Annual