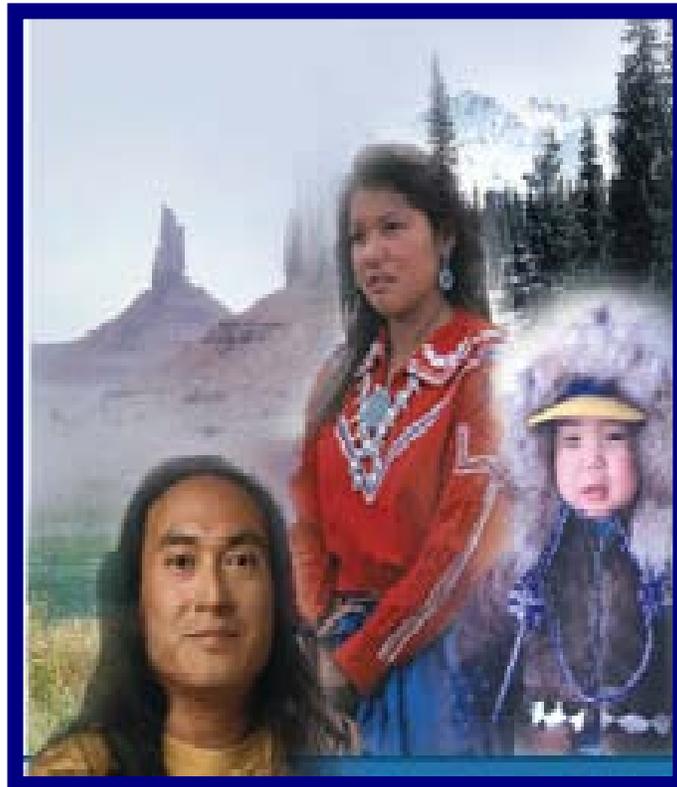




**Department of Health and Human Services
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry**

**3rd Biannual CDC/ATSDR Tribal Consultation Session:
Success, Challenges and Unmet Needs in Indian Country**



**August 12, 2009
Minutes of the Meeting**



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Acronyms

AIP	Arctic Investigations Program
AIR	American Indian Recovery
AoA	United States Administration on Aging
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
ATSDR	Agency for Toxic Substances and Disease Registry
BIA	Bureau of Indian Affairs
BRFSS	Behavior Risk Factor Surveillance Survey
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CCC	Comprehensive Cancer Control
CHS	Contract Health Services
CMS	Centers for Medicare and Medicaid Services
COTPER	Coordinating Office for Terrorism Preparedness and Emergency Response
CRIHB	California Rural Indian Health Board
DASH	Division of Adolescent and School Health
DGMQ	Division of Global Migration and Quarantine
DHS	Department of Homeland Security
DOD	Department of Defense
DSLRL	Division of State and Local Readiness
EOC	Emergency Operations Center
EPA	Environmental Protection Agency
FEMA	Federal Emergency Management Agency
FMO	Financial Management Office (CDC)
GPRA	Government Performance Results Act
HHS	Department of Health and Human Services
HICI	Healthy Indian Country Initiative
HIV	Human Immunodeficiency Virus
HRAC	Health Research Advisory Council
HRSA	Health Resources and Services Administration
IGA	Office of Intergovernmental Affairs
IHS	Indian Health Service
IRB	Institutional Review Board
MOU	Memorandum of Understanding
NARCH	Native American Research Centers for Health
NCHM	National Center for Health Marketing
NCAI	National Congress of American Indians
NCHHSTP	National Center for HIV, STD, and TB Prevention
NCI	National Cancer Institute
NCIRD	National Center for Immunization and Respiratory Diseases
NIHB	National Indian Health Board
NIMH	National Institute of Mental Health
NIS	National Immunization Survey
NPaiHB	Northwest Portland Area Indian Health Board
NVDRS	National Violent Death Reporting System
OCPHP	Office of the Chief of Public Health Practice
OD	Office of the Director (CDC)
OEC	Office of Enterprise Communication

OMHD	Office of Minority Health and Health Disparities
OSH	Office of Smoking and Health
PART	Program Assessment Rating Tool
PGO	Procurement and Grants Office
SAMHSA	Substance Abuse and Mental Health Services Administration
SNS	Strategic National Stockpile
SPAN	Suicide Prevention Action Network
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TCAC	Tribal Consultation Advisory Committee
TEMAC	Tribal Emergency Mutual Aid Compact
TLBC	Tribal Lands Building Credits
TTAG	Tribal Technical Advisory Group
US	United States
USPHS	United States Public Health Service
VA	Department of Veterans Affairs
VFC	Vaccines for Children

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

**Minutes of the Meeting
August 12, 2009**

Call to Order, Opening Prayer, Welcoming Remarks, Introductions

On Wednesday, August 12, 2009, the meeting of the 3rd Biannual CDC/ATSDR Tribal Consultation Session was called to order at 8:21am by Lt. Governor Jefferson Keel, Chickasaw Nation and TCAC Co-Chair. Mr. Keel welcomed the group to the meeting and thanked them for their participation. He introduced Angel Dotomain, President and CEO of the Alaska Native Health Board, who welcomed the group as well. Following an opening prayer, Mr. Keel asked for TCAC and CDC leadership to introduce themselves.

Chester Antone, Tohono O'odham Legislative Councilman and TCAC co-chair, welcomed the group. He expressed excitement about hearing the issues and needs of Indian country, and noted that the recommendations made would be taken back to CDC. Kathy Hughes, Vice Chairwoman, Oneida Business Committee, Bemidji Area and TCAC Co-Chair, welcomed the group as well. She stated that her role was to ensure that everyone is heard.

Dr. Stephanie Bailey, Chief, Office of Public Health Practice, CDC, greeted the consultation participants. She charged CDC with listening, honest dialogue and conversation, which she acknowledged was the only way that CDC and Indian country can move forward. She thanked everyone for their participation.

Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion, CDC mentioned that her division oversees the activities that are largely non-communicable diseases, chronic health conditions, diabetes, health promotion, maternal and child health, and many of the prevailing issues being discussed at the Consultation Session. She stated that she was thrilled to be there because she started her career in Alaska, and that she will continue to work with CDC and prioritize in her work with issues related to AI/ANS. Dr. Toomey remarked that it was a tremendous opportunity for her to be there to provide input, and to hear directly from Indian country so that CDC can better serve.

Stacey Ecoffey currently serves as the Principle Advisor for the Office of Intergovernmental Affairs, OS/HHS. She mentioned that her office was responsible for working with state, local, and tribal governments; they are the portal for those governments to work within the HHS, and they are also able to advocate tribal views and issues internally at HHS. OIA houses the Secretary's Tribal Consultation Policy (TCP), which allows them to work with the eleven HHS agencies to help coordinate their tribal consultation efforts, advisory committees, and any other work they do with tribes, to ensure that every agency follows the Secretary's TCP, while being good partners in the government to government relationship that they have with tribes. She commented that she was excited to be back in Alaska. She noted in the past, she has visited communities in Alaska with HHS leadership. She thanked the AK Natives for their hospitality and willingness to share their concerns so that people better understand the issues facing the

region. Additionally, she thanked the Alaska Native Health Board (ANHB) for all of their hard work during the planning process.

Dr. Frieden, newly appointed Director of CDC acknowledged the tribal leaders attending the Consultation by video, and expressed his sincere regret for not being able to attend the meeting. He thanked the Tribal Consultation Advisory Committee (TCAC) for their engagement in addressing priority public health issues facing AI/AN populations and communities. He stated that during the past few months as CDC Director, he has learned much about the health issues, concerns, and public health work in Indian country. He supports CDC's many partnerships with Indian country including efforts to ensure community based diabetes prevention and control programs, increase cancer screenings, to reduce disparities, and to strengthen the public health workforce in Indian country. He stated that he is looking forward to learning more from Drs. Stephanie Bailey and Kathleen Toomey, who are representing CDC at the Consultation Session. They, and other CDC staff will share a summary of the discussions and recommendations from the meeting, the health issues facing the communities such as tobacco and alcohol use, injuries, obesity, diabetes, and infant mortality are high priorities for CDC, as they are for Indian country. He stressed that CDC was committed to addressing those issues, and the profound health disparities affecting American Indian and Alaska Native (AI/AN) people. The government to government relationship between CDC and tribes, and their role in tribal consultation are critical to any efforts to address health issues in Indian country. He emphasized CDC's utmost respect for the tribal consultation process and their ongoing assurance to bring their resources and expertise on the health issues affecting AI/ANs.

Additionally, he mentioned that CDC relies on the TCAC for critical input and dialogue. He noted that he looked forward to meeting TCAC Chairman, Lt. Governor Jefferson Keel, and to working with TCAC members on health concerns. He stated that CDC was committed to assuring two Tribal Consultation Sessions each year; one in Atlanta, and one at a regional location. He noted that he was looking forward to the 2010 Tribal Consultation Session in Atlanta, where he plans to meet with the committee in person. He stressed that prevention was on the map today, as it has never been before. The Obama Administration, HHS, and CDC have a vision for health reform, and for advancing prevention and wellness, and that everyone plays a critical role as they move forward. He closed by saying that he is looking forward to their ongoing collaborative work to improve and secure the health of all people.

Other attendees from the meeting introduced themselves. A participant list can be found at the end of this document.

Regional/Alaska Focus Areas

Moderators

Angel Dotomain, President/CEO Alaska Native Health Board
Tom Hennessy, Director, CDC Arctic Investigations Program

Ms. Dotomain and Dr. Hennessey welcomed the group and thanked them for their participation. Ms. Dotomain stated that the morning session, which focused on Alaska issues, garnered a lot of assistance from the Alaska Planning Committee to ensure that issues that were specific to CDC, and programs that are run in the state of Alaska are made known, and that issues, challenges, and successes are also shared. She mentioned that the morning session would allow tribal program staff from each focus area to share information about the programs in

Alaska, and then there would be one or two scheduled tribal leaders that would speak, immediately followed by an open mike session.

Focus Area #1: Injury Prevention and Control

Kyla Hagan, Alaska Native Tribal Health Consortium (ANTHC), Injury Prevention Program

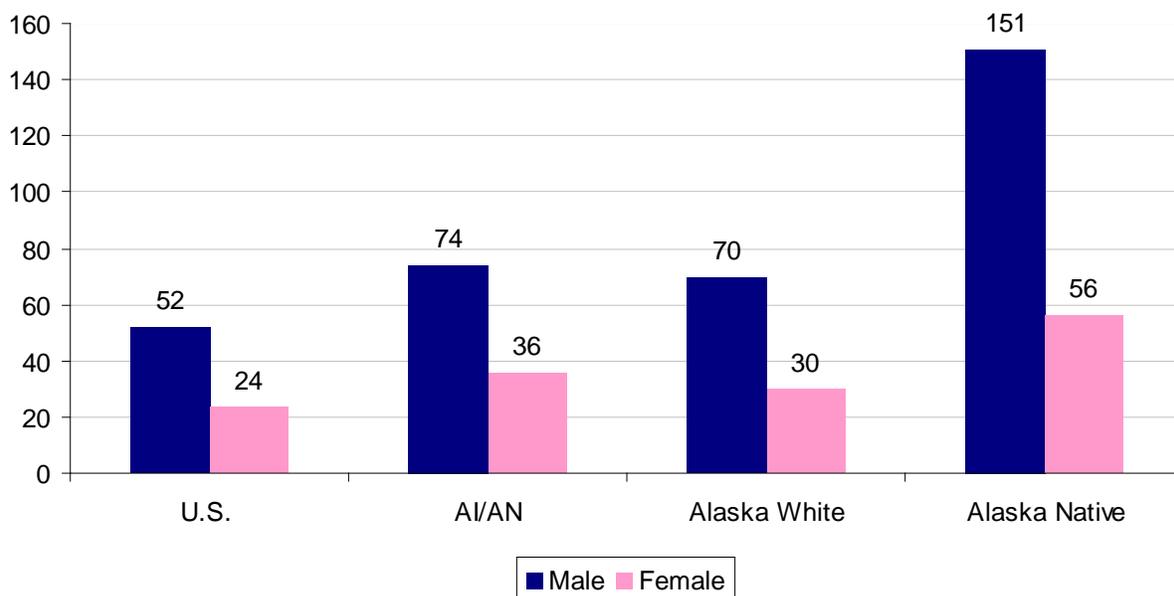
Barbara Franks, Alaska Native Tribal Health Consortium (ANTHC), Injury Prevention Program

Kyla Hagan stated that when all types of injury are combined, intentional and unintentional, they become the leading cause of death for Alaska Native people. She noted that evaluating Years of Potential Life Lost (YPLL) is another important way of looking at causes of death. YPLL accounts for the number of years lost due to a death earlier in life than expected. When injuries are considered, they account for 44 percent of YPLL for Alaska Native people.

Unintentional Injury Death Rates

Age-adjusted rate per year per 100,000, 2000-2006

Data Source: CDC WISQARS

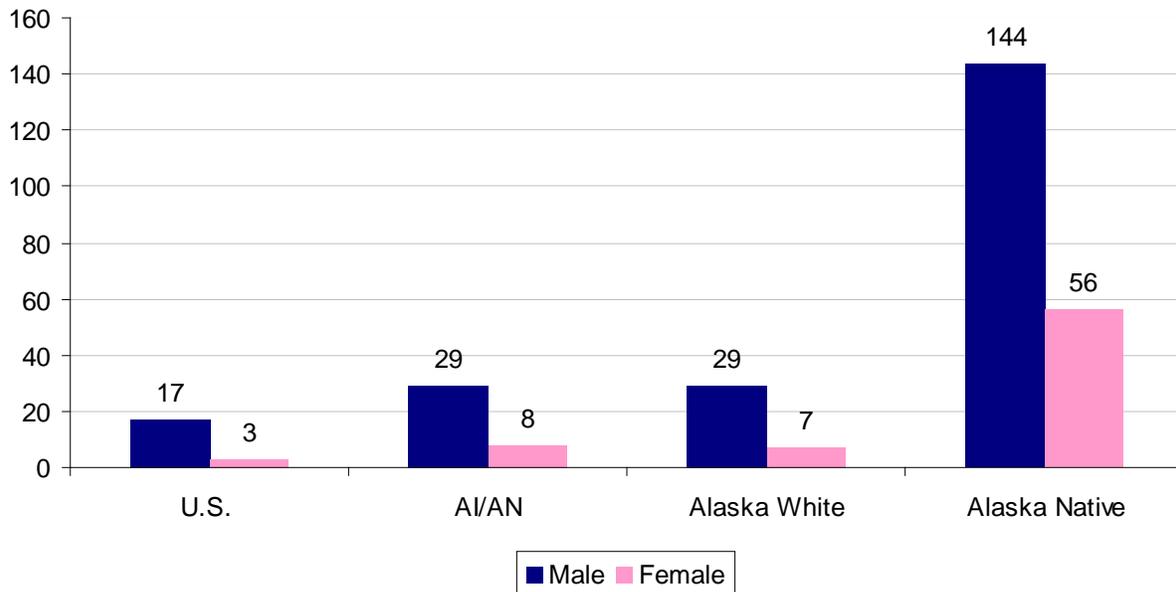


This chart shows the unintentional injury death rates for men and women for the U.S., the American Indian and Alaska Native population nationwide, Alaska Whites and Alaska Natives in Alaska. The Alaska Native death rate is three times higher than the U.S. death rate; and more than doubles that of other American Indians and Alaska White people. Alaska Native people have the highest unintentional injury rate of any I.H.S. region. Suicide, poisoning, motor vehicle crashes, drowning, and other land transport crashes are the leading causes of unintentional injury death in Alaska Native people.

Suicide Death Rates, Young People (15-24 years)

Age-adjusted rate per year per 100,000, 1999-2005

Data Source: CDC WISQARS



The suicide rate for Alaska Native people overall is three times higher than the U.S. population. The most distressing injury statistics is the rate at which Alaska Native young people are dying due to suicide, most commonly by firearm for men, and hanging for women; the largest disparity in young people ages 15-24. For Alaska Native men, the suicide rate is eight times that of the U.S. population, and even five times that for their Alaska White and American Indian peers.

Ms. Hagan indicated that another injury-related issue among Alaska Natives was elder falls. Falls result in the most hospitalizations of any type of injury in Alaska, and the highest rates were among the elderly. Alaska Native elders who fall face the same challenges as any elder who falls, but if assisted living or advanced care is necessary, they have to leave their communities because those facilities are not available in rural Alaska. Due to increased life expectancy, the Alaska Native elder population is estimated to triple over the next 20 years. The costs associated with care for elders who are injured from falls will become an immense burden on the Alaskan health care system if falls are not reduced.

Alaska Native people also suffer a disproportionate percentage of traumatic brain injuries. Alaska Natives only make up 20 percent of the population; however, ANs make up 33 percent of traumatic brain injury hospitalizations.

She noted as in other American Indian populations, Alaska Native women suffer from a large rate of intimate partner violence. A study by Rosay in 2005 found that Alaska Native women in Anchorage experience sexual assault at a rate that was 9 times higher than other women living in the city. Also, a medical professional responsible for post-mortem examination of victims of rape and murder reported to Amnesty International that of the 41 confirmed cases since 1991, 32 of them were Alaska Native women.

Ms. Hagan presented successful injury prevention projects in Alaska that included drowning death prevention, fire death prevention, and increase safe firearm storage and dog bite

prevention. Additionally, other projects included the “Kids Don’t Float (KDF)” program, which began as a grass-roots effort in Homer because drowning was common among children. As a result of the success of this program in Homer, the KDF program has been expanded to more than 500 sites throughout Alaska, supported by the State of Alaska. Other states and countries have since adopted it.

In addition, CDC and many of the Alaska Native corporations are working with the State of Alaska to install photoelectric smoke alarms throughout the homes in the villages. During the past two years, more than 1,000 smoke alarms have been installed in rural homes. In addition to modifying the environment (installing smoke alarms), the project also conducted education in the schools and in homes.

Ms. Hagan also reported on the recent gun safe installation project. This project involved installing a safety device in homes to reduce injury, and providing education to the homeowner. The final assessment of the project is currently being conducted, however, through surveys of the study participants; a 70 percent increase has been seen in the safe storage of guns. Additionally, there has been least one reported incident where the locked cabinet prevented injury (impulsive acts, adolescent suicides).

Ms. Hagan introduced Barbara Frank, also from the Alaska Native Tribal Health Consortium (ANTHC), Injury Prevention Program. Ms. Frank presented programs currently being conducted in Alaska related to Suicide Prevention. She stated that her culture and heritage pulled her through the last 12 years of her life. Her son was 23 years old when he committed suicide, two days before her husband died from cancer. The passion in her heart carries with her the lessons learned from her elders.

She mentioned that the ANTHC have a collaboration of wellness and injury prevention. Many of the programs that they have were researched in conjunction with the ASSIST Program. The reason they chose ASSIST was because they could train people to talk to others in their own area. So far, they have gone to seven communities, and have trained 138 people. They are also scheduled to have training in Anchorage in September.

Other programs currently being implemented include collaboration between Behavioral Health and Injury Prevention Programs, Applied Suicide Intervention Skills Trainings, the “Message of Hope” Media Campaign, as well as increased screening programs for depression.

Ms. Hagan stressed that the biggest challenge facing injury prevention is funding. More resources are needed for AI/AN injury prevention, as well as evidence-based strategies for youth suicide and elder fall prevention. Funding is also needed for technical assistance to explore protective factors in communities with low suicide.

Open Tribal Testimony

- Tribal Leader Bill Martin, President, Central Council Tlingit and Haida Tribes of Alaska (CCTHITA), gave testimony regarding Suicide Prevention. He acknowledged Barbara Frank and Lincoln Bean, Vice-Chairman, Alaska Native Health Board (ANHB) for their work. He commended people like Ms. Frank, who had a double funeral for husband and son, but still gives of her time and travels from town to town sharing her testimony. He noted that suicide prevention in Alaska was stagnant; they struggle for answers, look at statistics, and analyze data. He noted that the highest months for suicide in Alaska were

April and August, but no one could explain why. He was reminded of an incident that took place when he was a little boy where his uncle explained to him that a young man that they knew had committed suicide. Mr. Martin commented that the incident troubled him so much that he vowed to never kill himself with a shotgun; he tried to hang himself instead several years later. He stressed that the thought of suicide was not new to Alaska Natives, and that the thought was with them almost all of the time. He mentioned that Alaska Natives, and Native Americans around the country are very spiritual people, and have a high acknowledgement of their ancestors; "the one above all" is there to guide them through the tough times. This is what Alaska Natives use to cope with the issues of life. Additionally, he stated that alcohol exacerbates the effects of depression. He noted that suicide among young Alaska Natives was almost always alcohol related. He stressed that the problem could be fixed by being advocates like Ms. Frank, in addition to holding conferences, and consultation sessions with tribal leaders. He commented that tribal leaders needed to stress that suicide in Indian country is a serious matter that needed to be addressed, even though nobody wants to discuss it. He urged tribal leaders to put suicide on their agendas. He stated that his tribe put together their own suicide group that travels to the various towns and villages to discuss suicide. Mr. Martin mentioned that the highest rate of suicides in the U.S. was among elders. However, in Alaska, young people between the ages of 15 to 26 have the highest rate of suicide, with the elders being the lowest. Alaska Natives praise and glorify their elders, and give them their own special place; ANs go to their elders for advice, as well as serve them, which make them feel good, important, and feel as though they still contribute to their communities. Mr. Martin stressed that the same needed to be done for the youth. He shared that a seven year old girl had committed suicide, riddled with hurt and pain that no one ever addressed. He urged everyone to help the kids understand that the best is yet to come.

- TCAC Co-Chair Kathy Hughes, Vice Chairwoman, Oneida Business Committee, Bemidji Area, noted that one of the problems that CDC could address was on their website; the brochures state very little about Native Americans. She argued that the brochures needed to be culturally sensitive. She stated that they always address the Pacific Islanders, African Americans and Hispanics, but there is hardly any information regarding Native Americans. She also stated the competitive nature for grants was difficult for Indian country. AI/ANs need to have specific set asides of funding sources to help address prevalent issues. She stressed that trying to compete for grant revenues with the rest of the country, whose rates are not nearly as significant as they are in Indian country, is an additional challenge for them that CDC could easily eliminate. Additionally, she stated that the grants needed to be long term; the programs are developed during the first several years, and that it was difficult for Indian country to deal with issues in one, two, or three year increments. CDC should consider funding five year cycles to give assistance to AI/ANs.
- Tribal Leader Cynthia Manuel, Tohono O'Odham Legislative Council, commented that more funding was needed for Injury Prevention in the area of Domestic Violence. She stated that her tribe has a safe house that is funded by the tribe. She mentioned that her tribe had not received any grants that they have applied for. She stated that they are constantly searching for funding for prevention because the funds that the tribe provides are not sufficient. They would like to reach more people, but try to do what they can with the tribal funds that they have.

- TCAC Member Ching King, Ft. Belknap Indian Community, thanked Chairman Martin for his comments. He commented that suicide should be on the top of every council's agenda. In addition, he stated that funding seemed to be the main issue for tribes. He added that Indian country was comprised of 500 plus tribes that were all culturally different, therefore cultural sensitivity was imperative. Additionally, he stated that suicide among Veterans was an issue within his tribe that was difficult to address because neither the VA nor I.H.S. wanted to take responsibility. He noted that the tribes have difficult relationships with the states because tribal numbers are used by the states to get funding, however, when the tribes ask for resources, the states tell them they do not qualify. Tribes have to be very creative with their programs due to the lack of resources.
- TCAC Member Derek Valdo, National Congress on American Indians (NCAI) Southwest Area Vice President, Pueblo of Acoma, commented that Dr. Toomey had the opportunity to visit the Pueblo of Acoma and asked during that time "if you had a blank check, what would we do to produce better results in prevention". He responded that he would like to go back to their cultural values. He shared that in Acoma, there was a system in place where the fathers and the uncles of each family were the keepers of the family's values, morals, and traditions, and they are the ones that set the expectations for the family. He commented that he blames MTV, satellite TV, and the internet for the degradation of their cultural values. He added that the Pueblo of Acoma was a very small close knit community, roughly 4500 tribal citizens, in a small area. Recently, they have experienced two successful suicides, and five attempted suicides, which was extremely rare for their small tribe. He affirmed President Martin's statement, adding that he sent information out to tribal councils stressing that suicide needed to be addressed; he received no response. He echoed the cultural sensitivity comments, and added that the Alaska Federal Health Care Access Network (AFHCAN) model might be successful model for the lower forty-eight. He added that capacity, infrastructure, and funding dollars are always very important in Indian country.
- Tribal Leader Corrine Garbani, Pechanga Band, commented on the necessity for peer review. She added that Indian country was not afraid to compete for funding, and that they definitely have the programs that are capable of competing. However, if CDC utilizes objective reviewers that do not really know AI/AN communities, the reviewers will not understand what they are reading. Ms. Garbani noted that AI/ANs hold themselves to very high standards, even more so than anyone else would. She encouraged CDC to utilize more qualified peer reviewers for AI/AN specific money.
- TCAC Member Governor Leon Roybal, Pueblo of San Ildefonso, remarked that cultural sensitivity needed to be equally balanced both within Indian country, as well as in the rest of the population. He stressed that it was imperative for AI/ANs to maintain their cultural heritage, as well as educate themselves with the outside world. Indian country has to commit themselves to develop preventive ideas and programs because they are, unfortunately, no longer self-sustaining as they were 100 years ago.

CDC Respondents

- Holly Billie, CDC National Center for Injury Control, responded that she was a Navajo from Montezuma Creek in Southern Utah, and just recently transferred to CDC. She previously spent 18 years working in I.H.S. in Indian prevention. She added that Ms. Hagan's presentation brought back a lot of memories of the Alaska programs she had

the opportunity to work with like the Float Coat and Dog Bite Programs. She has also had the opportunity over the years to work with a number of tribes, more recently dealing with the issue of Suicide Prevention. She learned through interaction with several tribes that working in Unintentional Injury was very different from working in Intentional Injury. Unintentional Injuries have proven strategies that are basically cut and dry; if there is a drowning issue, a Float Coat Program could be easily implemented. Seatbelt Programs are implemented for motor vehicle problems. However, for topics like suicide, which are very emotional and sensitive, there are no cut and dry solutions. There are some proven and effective strategies, but it is more difficult to reach the place of knowing what exactly is going to work. She stated that Ms. Hagan made a request to CDC regarding the provision of Epi Aids to conduct in Alaska. Epi Aid is a mechanism of CDC to respond to urgent and emerging health issues. She mentioned that this had already been done in the area of Suicide Prevention in some of the northern states in the lower forty-eight. She added that Dr. Alex Crosby, Center for Injury Prevention, Violence Prevention Branch, stated that the core criteria for doing an Epi Aid at any location is that there has to be an invitation from the local community. It is not something for CDC to come in and invite themselves to conduct the Epi Aid. She mentioned that Dr. Crosby would be happy to discuss the pros and cons, and also their experiences with native communities. She noted there was a strong possibility that CDC could bring Epi Aid to Alaska.

Ms. Billie also stated that one of the issues mentioned earlier was concerning funding, which comes with every health issue. She indicated that currently, CDC was not well funded for Suicide Prevention. However, she commented that it was good that this topic was brought up for CDC to address. She acknowledged the frustration with applying for grants, which she noted was one of her job functions when she worked with tribes at I.H.S. She urged tribal leaders to not ignore the small pockets of funding because they were generally not as competitive; the 10 to 50 thousand dollar grants, where tribes could start with things like ASSIT Trainings that Ms. Hagan mentioned earlier, were valuable. She stated that she has worked with tribes that started with similar programs to make themselves more competitive for other funding. Her recommendation to tribes was to not ignore the smaller pots of funding while still voicing their concerns about making the larger funding options available for tribes.

Another request that was sent to CDC was to provide assistance in implementing effective Safety and Suicide Prevention Interventions for youth; especially utilizing the internet and new media. Ms. Billie mentioned that there was a meeting that CDC and Dr. Crosby would be attending in late August to discuss these issues since the youth are heavily involved with the internet and texting. The meeting would address how these type tools could be used to reach out to youth. She stated that the group could expect recommendations to come forth very soon.

The final request made to CDC was to provide funding to pilot tests dealing with Youth Prevention Suicide strategies in the Alaska Native population. Ms. Billie stated that Dr. Crosby wanted her to point out that CDC may be able to do something in this area next year for 2011 funds.

- Dr. Stephanie Bailey, Office of Public Health Practice, CDC, thanked Ms. Hollie for her responses, noting that they were very attentive to the needs communicated by Indian country. She commented that the presentations were enlightening, and the strategic thinking around surveillance, evidence-based strategies, and exploring protective factors in communities was in alignment with Dr. Frieden's focus at CDC. Dr. Bailey affirmed

that Dr. Frieden was trying to reorganize CDC with great effort in order to capture CDC's greatest strengths like surveillance, evidence-base, and getting to results by focusing on government, state, local and tribal relationships. She applauded the testimonies which pointed out that even though there is little funding available, Indian country was not just sitting around waiting, and watching the youth and their communities die. She stressed that CDC has noticed their efforts. Suicide is about relationships, and is an issue that should exist on all tribal agendas because it becomes a community problem. She added that Peter Benson conducted research and produced a book entitled "All Kids Count," which talked about the 40 assets within the community that empower kids to grow and become successful. She stated that it was incumbent on CDC to have information accessible on the website in a way that people could understand, as mentioned previously. Regarding the funding cycles, Dr. Bailey noted that CDC was looking through various mechanisms to look at how CDC can reshape their ability to dispense funds, and to allow for the effectiveness to occur in an efficient time period. She added that Rob Curlee, Deputy Director, CDC Financial Management Office, would address the group in greater detail concerning funding.

Focus Area #2: Chronic Disease Prevention and Control

Oral Health

Dr. Sarah Shoffstall, Alaska Native Tribal Health Consortium (ANTHC), DENTEX Clinical Site Director

Dr. Shoffstall reported that in response to extensive dental health needs and high dental vacancy rates, the Alaska Dental Health Aide Therapy (DHAT) program began in 2003. The DHAT program is part of the Community Health Aide Program (CHA Program), which is authorized under Section 119 of the Indian Health Care Improvement Act. The CHA Program started in the 1960s by the Indian Health Service to provide emergency, clinical, and preventive services under general supervision of physicians. Following the CHA Program model, the DHAT program selects individuals from rural Alaska communities to be trained and certified to practice under general supervision of dentists in the Alaska Tribal Health System.

The Alaska DHAT program was created in part due to the high rates of dental caries and overall lack of access to dental services in rural Alaska villages. Alaska Native children and adolescents suffer dental caries rates at 2.5 times greater than general US children and adolescents. This, combined with a vacancy rate of 25 percent and 30 percent annual turnover rates in dentists has developed into a serious problem in Alaska dental care.

Alaska's DHATs receive extensive training, certification, continuing education, and clinical reviews to ensure their skills are of the highest quality. Alaska's first DHATs received their training at New Zealand's National School of Dentistry in Otago. The first DHATs graduated in 2004. In 2007, the Alaska Native Tribal Health Consortium, in partnership with the University of Washington's MEDEX Northwest Physician Assistant Training Program, opened DENTEX, the first DHAT training center in the United States. The DENTEX goal is to provide culturally sensitive patient-centered care to optimize prevention to ensure that patients feel comfortable enough to return for continued care and treatment. The DENTEX program is extremely rigorous. Students receive two years of training in biological science, social science, pre-clinic, and clinic training. The students receive 2400 hours of training and clinical experience during their first year in Anchorage and during their second year in Bethel, Alaska. Utilizing the same textbooks as dental students, DHATs in training are trained to provide the same high quality level of care a dentist would within their limited scope. The DENTEX faculty, most from dental schools,

ensures that the students meet all skill requirements throughout their training. The training also consists of extensive clinic training. In fact, 20% of the first year of training and 78% of the second year of training consists of clinical components.

Successes of the program include the Yukon-Kuskokwim Health Corporation Epi-Aid Study, as well as the development of Remote Operating System (ROS), which is a simple, low cost way to ensure safe and effective water fluoridation in rural villages. Dr. Sarah Shoffstall addressed major challenges such as decay rates, vacancy rates, and behavioral health components of oral health care such as tobacco cessation, diet modification and oral home care. Specific requests made to CDC regarding the area of oral health included the need for developing other treatment modality effectiveness studies, efficiency studies that include primary dental health aid and dental therapist, and Alaskan campaign that informs the population that carries are a transmittable, infectious disease; and diabetes.

Cancer Among Alaska Native People

Christine Decourtney, Cancer Program Planning Manager, Alaska Native Tribal Health Consortium (ANTHC)

Ms. Decourtney reported that cancer was the leading cause of death in Alaska Natives. She presented that the first Comprehensive Cancer Plan for the Alaska Tribal Health System was completed, and provided a foundation for them to have a real plan to address the burden of cancer among Alaska Natives. Ms. Decourtney commented that Alaska Natives have survived thousands of years in the beautiful, but harsh Alaska environment by creatively using any, and all available resources. To implement their cancer plan, ANTHC has created many resources, and have worked with many tribal, private, and government partners to address their cancer burden, but are still lacking in resources.

Ms. Decourtney shared one innovative way that ANTHC has used to address their cancer issue. Lu Young was the wife of an Alaskan Congressman who recently passed away. She started the Lu Young Fund for Children of Families Fighting Cancer in 2004 to help cancer families. It funds such things as Camp COHO, a grief camp for kids. Camp COHO was designed for kids ages 6 to 12 who lost loved ones or close family members to cancer. The camp was designed to help them learn how to cope with the loss. The main funding is through the Invitational at the Alaska Cedar Life Center each fall. The day camp, the first of its kind in Alaska, provides grief information and support through a number of activities, including creating a memory box, participating in healing circles, and team relays and games. The camp's activities are based on a national grief camp model, and adapted to honor Alaska Native cultural ways. Campers interact with other children who have also lost a family member to cancer, and learn healthy ways to remember their loved one and better understand their own feelings. Children are given the opportunity to speak about their loved one and to tell stories about happy memories. Adults pair with each child. They spend the day together, and exchange their stories and feelings. Many children reported that they learned that it was "o.k." to cry, and some parents reported that children were more willing to talk about their loss after attending the camp.

Ms Decourtney reiterated that ANTHC was very short on resources to implement all parts of the Cancer Plan. They are trying to figure out ways to address the problem, Camp COHO being one example of a creative way they chose to deal with the problem.

Cardiovascular Disease and Obesity

Janet M. Johnston, Health Research Director, Alaska Native Tribal Health Consortium (ANTHC)

Ms. Johnston reported that traditionally the Tribal Health System is focused on Acute Care, with heavy emphasis on Infection and Injuries. More recently, however, there is growing awareness that chronic disease prevention and management must be an important part of the health care system; both in order to improve the health of the of the AI/AN population, and help get costs under control.

Recently leaders in the Alaska Native Tribal Health System were asked to identify their top health concerns. The three issues that were mentioned most frequently were cancer, management of chronic disease, especially diabetes and cardiovascular disease, and disease prevention. Recent success in these areas include cardiovascular disease screening and lifestyle interventions provided to Alaska women through the CDC funded Tribal WISEWOMAN programs, comprehensive tobacco cessation activities across the state, increased awareness of chronic disease incidence and risk factors, and increased use of telemedicine and case managers to help Alaska Native people throughout the state manage chronic conditions.

Despite these successes, the Tribal Health System is barely scratching the surfacing in terms of addressing chronic disease prevention and management. Alaska Native people currently experience very high levels of risk factors for cardiovascular disease and metabolic syndrome. These include high levels of pre-diabetes, hypertension and pre-hypertension, and overweight and obesity. For example, among the Alaska participants, 49 percent of the women, and 32 percent of the men were clinically obese. Another 29 percent of women and 32 percent of men were classified as overweight. This concludes that the large majority of Alaska women and more than half of Alaska men are overweight or obese.

In a relatively short period of time, the Alaska Native lifestyle has shifted from a subsistence lifestyle, to one that is more mechanized and sedentary. At the same time, the diet has shifted from nutrient -rich subsistence foods to increasingly processed nutrient-poor foods. Complicating all of this is a background of historical trauma, family disruption, and behavioral health concerns.

Clearly, there are many unmet needs in the area of Chronic Disease Prevention and Control. There is a pressing need to counter the lifestyle changes that have led to reductions in physical activity, and changes in diet. Unfortunately, in many ways, this is the "Holy Grail" of chronic disease management. There are many recommendations for health levels of physical activity and health diet; however the question remains of how to make people make the necessary changes to be in compliance with these recommendations. This research is needed to develop sustainable approaches that will support clinical relevant rejections in chronic disease risk factors. Given the physical differences between Alaska, particularly their remote locations, and the places where most of the prevention research is being conducted; and given the cultural differences between the Alaska Native and American Indian communities, and the communities where many evidence-based practices have been developed, there is need for research to clearly understand, test, and determine how to modify interventions for use in their communities. There is also a need to develop new approaches based on local knowledge.

In developing programs for addressing cardiovascular disease and obesity, Ms. Johnston asked that they particularly focus on including native experts who understand the native view of wellness as harmony of body, mind, and spirit, and to be sure that these programs integrate

behavioral health and chronic disease prevention and control. She specifically asked the CDC to consider funding in Alaska-based Prevention Research Center. She also asked that whenever possible, if CDC would allow tribal organizations to apply for funding that is open to the state. She noted that there are many situations where the tribal organizations are better suited to come up with programs that will be effective in the tribal communities. She stressed that ANTHC was very interested in partnering with the state organizations and universities, but in many cases letting the tribal organizations take the lead will result in more effective programs. When it is not possible to allow funding directly through the tribes, ANTHC asked for concerted efforts to make the states accountable for including tribal participation in statewide programs, including specifying requirements for tribal participation, and possibly naming and funding tribal participants to ensure there is meaningful tribal participation.

Ms. Johnston thanked the group for their time, and welcomed the opportunity to discuss in more detail the issues affecting the tribes related to chronic disease and management.

Diabetes Among Alaska Native People

Leera Lynch, Diabetes Program, Alaska Native Tribal Health Consortium (ANTHC)

Ms. Lynch stated that a Diabetes Registry was started and maintained at CDC from 1985 to 1991, and still continues to be a great tool for following up with patients, gathering data and getting the information back to tribes. Another success has been new and expanded programs through the Special Diabetes Program for Indians funding that started in 1998, which has been extended because of its success in helping to establish programs throughout Alaska. In addition, there have been lower amputation and renal replacement rates, improved metabolic profiles, and ongoing data analysis help from the CDC Arctic Investigations Program.

Ms. Lynch reported that the number of people living with diabetes in Alaska has increased. In 1985, there were 610 people living with diabetes in Alaska; today, the number has climbed to almost four thousand. She noted that the prevalence of diabetes varied throughout the state. There is a four-fold difference in diabetes prevalence. She indicated that there are regions where the rates are really low, and then there are areas where the disease is more prevalent.

Some of the needs and challenges for the Alaska include primary prevention of diabetes. As Ms. Johnson indicated, the lifestyle changes have really taken a toll, and there is a great need for prevention programs that promote behavior change within a wellness model that work for Alaska Natives. What is needed are programs that can be tested and modeled in Alaska, that work specifically for Alaska Natives. Every region has its own way of doing things; therefore, Alaska desperately needs to be able to apply for funding that can create Alaska specific programs.

SEARHC Program

Nancy Knapp, Southeast Alaska Regional Health Consortium (SEARHC)

Ms. Knapp reported successes of the SEARHC Program include the CDC funded programs that really work closely together to reach across the socioecologic model to affect public health outcomes on many important levels. Through the integration of their various CDC funded programs, they have been able to document some significant public health effects on the population of Southeast Alaska, including drops in tobacco rates, drops in CVD risks for women, numerous policy changes, increased chronic disease screening rates, as well as new hopes for

their newest CDC grant that is funded through the Native Diabetes Wellness Program called the Traditional Foods grant, which they feel is cross-cutting prevention at the most primary level.

SEARHC has many challenges in implementing their CDC grants as well. They find that they really have to design and adapt their programming to address the needs of their communities. Most of their communities have their own strategic plans; therefore the goal at SEARHC is to weave health into the strategic plans. They find that unresolved trauma in their population has profound effects on chronic disease outcomes. The Adverse Childhood Event Study (ACE) was utilized to adjust SEARHC's programming to address this issue as efficiently as possible. In addition, SEARHC must balance their evidence-based methods with the adaptation to the cultural and geographic conditions in Alaska, which is a difficult thing to do.

For some of the CDC programs that conduct cost effective analysis and fund Alaskan programs on a per person basis is difficult because everything in Alaska costs more. Additionally, the program guidance that they follow is generally set up for state health departments, and this does not translate well to the tribal groups. SEARHC is a complicated healthcare delivery system and the guidance takes them off track. The healthcare system is very relationship-oriented, and sometimes the population-based approaches that are funded through CDC may not always address how SEARHC does business.

In terms of unmet needs, SEARHC has found that CDC silos can make program integration challenging, inhibiting synergistic outcomes; some of the implications to their funded programs can be profound. As mentioned before, SEARHC really sees behavioral health as a missing partner in much of their programming, most notably in the area of unresolved trauma and chronic disease outcomes. Furthermore, Ms. Knapp indicated their policy work needed to be balanced by one-on-one services, specifically in the area of tobacco cessation. Lastly, the loss of their Steps Program will leave a large gap in the policy arm of what SEARHC does in Southeast Alaska.

There was no Tribal Testimony under the area of Chronic Disease Prevention and Control.

CDC Respondents

- Rose Marie Henson, Deputy Director, CDC National Center for Chronic Disease Prevention and Health Promotion, stated via teleconference that her center has had a long standing relationship with the tribal community. She commented that CDC understands the messages that were shared, and that they truly value having direct funding relationships with the tribes, but clearly need to do more as more resources become available for chronic disease. In addition, she affirmed the comment of where CDC puts dollars through states to ensure that states are working closely, and in an effective manner with tribes. She noted that there were other members on the line from her center that were available to answer specific questions or address specific issues that needed to be brought to their attention.
- Nicholas Burton, Public Health Analyst, CDC National Center for Chronic Disease Prevention and Health Promotion, commented that the main message is that this is a different time for chronic disease. He stated that with President Obama and Dr. Frieden, there was a renewed interest within CDC in the area of chronic disease, and they were really looking forward to working closely with Indian country to address their issues. He understood that while tribal leaders may not have many specific issues

to share, he noted that he was looking forward to following up with everyone regarding new issues.

- Ms. Henson asked what the key priorities were within the area of chronic disease so that CDC could develop a strategic plan.
- Angel Dotomain, President/CEO Alaska Native Health Board, responded that there was information in the packets specific to the areas of chronic disease and prevention that Alaska Natives were most interested in which included cancer care, cardiovascular disease, and diabetes. She stated that if there were others, she would make sure that they were brought to CDC's attention.
- Tribal Leader Sally Smith, Chairman, Bristol Bay Area Health Corporation (BBAHC), commented that continued partnerships between agencies were taking place on a national scale. She urged that the relationship between CDC and I.H.S. continue to be fostered. She mentioned that the mantra "is it good for native people", always be taken into consideration as CDC continues to make decisions regarding Indian country. Also, she noted that on September 14, 2009, a meeting was scheduled to take place at the Indian Museum in Washington D.C. dealing with issues related to diabetes.
- Tribal Leader Ileen Sylvester, Southcentral Foundation, commented that it has been a blessing to work for over 14 years with tribal leadership in their region to make decisions about how to provide health and other related services to the people they serve. She noted a study conducted by CDC which looked at the impact of early child hood trauma, and its impact on physical health. Southcentral Foundation has a program called Family Wellness Warriors' Initiative, which is a movement that brings together leaders of the Alaska Native Community, the faith community, regional corporations and agencies, health care providers, and many other interested people in an effort to restore wellness to the Alaska Native Community. It specifically addresses all forms of violence that occur within the family. These include child abuse and neglect, sexual abuse, vulnerable adult abuse and neglect, domestic violence, and adult sexual assault. The purpose of FWWI is to encourage and promote family wellness, utilizing long traditions of Native people's strength to counter all types of domestic violence, neglect and abuse within this population. It addresses these issues through a comprehensive, holistic approach, mobilizing the resources of numerous organizations, agencies and communities statewide, both urban and rural. The program had a larger impact on issues such as cardiovascular disease, cancer, and obesity. She stressed the need for partnerships and support to continue programs like FWWI.
- Dr. William Kohn, Associate Director for Science, CDC Division of Oral Health commented that the challenges with dental caries have been in Alaska for a long time, and to hear the disease rates are still high was disturbing. He noted that his division was a very small division with a large amount of responsibility, primarily focusing on community water fluoridation, and dental office infection control. The broad range of community prevention was new to his division which has recently led to their collaboration with states to try to develop innovative programs to address caries. As Dr. Shoffstall presented, the need to develop other treatment modalities and effectiveness studies was something that his division accomplished in collaboration with other partners such as the National Institutes of Health, the American Dental Association, and Medicaid Services. He added that the efficiency studies with other health providers were very

important. Dr. Kohn noted one thing to keep in mind was that every dentist that graduates from school thinks that they can go out in their community and treat away every disease; however, they quickly find out that this is absolutely impossible, they key is prevention. He stressed that tooth decay was almost 100 percent preventable. The large disparities must be effectively addressed. He stated that there was no reason for any child born from today through the next five years to experience decay. The focus needs to remain on prevention. He indicated that community water fluoridation and school sealant programs are important in addition to behavioral aspects such brushing, and good diet. He assured the group that the CDC Division of Oral Health would have great sensitivity towards the current issues within Indian country, and would assist in any way possible.

- Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion, CDC added that all of the work mentioned was critically important. She stated that nationally, the health of the nation was not improving, and AI/ANs emerging and worsening issues like diabetes was important for CDC to acknowledge and address on the federal level. She mentioned that 20 years ago she could count on one hand the number of people with diabetes in the region. When she had the chance to meet with Derek Valdo in Acoma, she was struck by how often acute care took precedence over prevention. She added that many times when there were people with end stage renal disease due to diabetes, care had to be provided for them. What gets lost is the opportunity to try to prevent diabetes from happening in the first place. She stressed the need to work together to make prevention an absolute priority for AI/AN populations. Behavioral health was another very important issue brought up during the presentations. It is critical to think about wellness, and not just absence of disease. Unfortunately, there are categorical programs that do not necessarily embrace behavioral issues across the board. But what was consistently heard is that there needs to be commitment to behavioral health interventions. Behavioral health and physical health are inextricably linked. Also, she affirmed that the need for CDC to reconsider the way the grants are written, and that they reflect the reality of how the populations they serve can understand, acknowledge, and accept those interventions. She acknowledged the presenters that expressed concerns with interventions that worked in the lower forty-eight, but do not necessarily mean that it will work in an AI/AN community. CDC needs to allow flexibility to have their programs reflect the realities in Indian country. At the same time, she stressed the need for CDC to drive a research agenda to give AI/ANs the evidence-base. Lastly, Dr. Toomey stated that CDC needs to consider how they can work with Indian country to address policy changes that can make healthier communities. She noted that throughout the presentations, she saw instances where CDC funding left, and it was difficult to have the resources and expertise available to assist Indian country with making changes within the community. She noted that sustainable changes will come from policy change. Programs come and go, but policy can sustain, and continue to change and improve health. She applauded all of the programs, and stated that Camp COHO was a Suicide Prevention Program, and not just a Cancer Program. It addresses mental and behavioral health issues in a very proactive way.

Focus Area #3: Maternal and Child Health

SIDS and Infectious Disease

Jim Burner, Senior Director for Science, Division of Community Health, Alaska Native Tribal Health Consortium (ANTHC)

Mr. Burner reported that infant mortality rate is defined as the number of deaths within the first year of life per 1,000 live births. The neonatal mortality rate is defined as the number of deaths within the first 28 days of life per 1,000 live births. The post-neonatal mortality rate is defined as the number of deaths between 29 days and one year per 1,000 live births.

He commented that the infant mortality among Alaska Native babies was very high when he moved to Alaska in 1974. Although there was a significant decrease (48 percent) in the infant mortality rate for Alaska Native infants between 1980-1983 and 2004-2007, the rate remains twice that of Alaska Whites. This disparity is largely found during the post-neonatal period.

Alaska Native women are 3 times as likely to smoke during pregnancy as Alaska White women, which is a major risk factor for SIDS, the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. However, between 1996 and 2007, there was a 6 percent decrease in the percent of Alaska Native women who reported smoking during pregnancy. The percent of mothers who use smokeless tobacco during pregnancy is greatest in southwest Alaska. In the Yukon-Kuskokwim region, 41 percent of mothers report using smokeless tobacco during pregnancy. There has been a steady decline in the percent of Alaska Native women who report alcohol consumption during pregnancy. Between 1996 and 2007, the disparity between Alaska Native women and Alaska White women decreased from 4 times greater to 1.5 times greater.

In addition, Alaska Native children have a very unusual burden of severe infectious disease. Environmental factors like piped water and housing are major contributors. Dr. Burner noted that there were things that could be improved, but even so, AN children have a higher rate of hospitalization for severe respiratory disease in the first year of life, which is five to seven times higher than the U.S. rate for infants in the first year of life. There are other infectious diseases that are unique in addition to those that are common, one being Carious Diseases, which is an infectious disease.

Helicobacter Pylori infection of the stomach is another common condition identified in Alaska Natives. This infection causes ulcers in the stomach. For Alaska Natives, 85 percent of rural children are already infected with this organism by the time they are 10 years old. It accounts for the five times greater average risk of gastric cancer among Alaska Natives. It also accounts for a lot of the childhood anemia, which has major impacts on school learning. He noted that one of the things that is an unknown contributor to this risk is the presence of dental plaque. Dental plaque is a sanctuary for Helicobacter Pylori. There is a lot of interesting biologic research that needs to be conducted in Alaska regarding lowering the risk for re-infection, and in the long term the risk for other diseases, by treating the dental plaque and reducing the risk of re-infection from that protected area that cannot be easily addressed with antibiotic therapy.

Dr. Burner acknowledged that ANTHC has received a large amount of help from CDC, particularly from the Arctic Investigations Program (AIP) in looking at the risks and disparities in the health of the mothers and babies in Alaska.

Sexually Transmitted Disease in Alaska Native People

Jessica Leston, STD Program Manager, HIV/STD Prevention Center, Alaska Native Tribal Health Consortium (ANTHC)

Ms. Leston reported that Alaska has had the highest rate of Chlamydia in the nation. The disparities exist specifically in the Alaska Native female population, who has over 10 times the rate of the U.S. general population for Chlamydia. The disparity also exists among the youth in Alaska, with the 15 to 24 years olds having case rates of four to five thousand cases per one hundred thousand people.

More recently, ANTHC was able to evaluate Gonorrhea data, which indicated that Alaska Natives have rates higher than the U.S. as well as the overall state. Last year Gonorrhea cases in AN females increased 19 percent, and cases in AN males increased 53 percent. She noted that the state of Alaska Division of Epidemiology recently released a special bulletin which highlighted the increase in incidence of Gonorrhea in the southwestern region of the state. The data showed that within a year, there has been a 171 percent increase in Gonorrhea cases in this area, primarily in young AN females.

Ms. Leston provided successes within ANTHC that have been highlighted over the last several years which includes increased understanding of STD/HIV data, increased awareness of STDs/HIV within the Tribal Health System, and increased focus on women and youth, which are the people that have the highest morbidity and infection in Alaska.

Challenges include the ability to look at data on a level that is useful for the Tribal Health System to get Alaska Native specific data, not by census area, but by Tribal Health Corporation area, so that they are able to use the information to build their programs and guide their policy. In addition, Tribal Health Organizations are overburdened with issues. For the entire state of Alaska, there is one program that focuses on HIV/STD prevention for Alaska Native people. There is also a lack of information and research to guide effective behavioral and clinical interventions for AI/ANs specifically. She also noted that few projects, and even fewer programs that are directly funded at the tribal level for ANs was another challenge.

To resolve these issues, she stressed that technical assistance and resources were needed to enhance the current programs and policies at the tribal health level. Additionally, more collaboration is needed with AI/AN STD programs for effective behavioral interventions for Alaska Native people, and for CDC recommended guidelines for AI/AN specific programs. Finally, funding is needed for effective behavioral interventions for ANs, as well as extending funding eligibility to tribal STD programs, and not just state programs.

Open Tribal Testimony

- Dr. Ted Mullah, Director of Traditional Healing, Alaska Native Medical Center, Director of Tribal Relations, Southcentral Foundation, commented that the NIH program called EARTH, which empowered tribes to start training their own people to be researchers, and to help them set priorities to determine what they should do, was an excellent program that could be modeled. He encouraged CDC to be consistent, and to assist Indian country with training their own to perform research. He emphasized that there were lots of young people that are excited about working with CDC but have no idea of how to start the process. He urged them to be proactive partners. Additionally, he commented that people were underutilizing Traditional Healers. He noted that when Traditional Healers work with patients, they encourage them to take responsibility for themselves, which coincides with prevention. He recommended that CDC partner with Traditional Healers in the future. He stated that ANMC is the only facility in the U.S. that

has a Traditional Healing Clinic that is accredited by the joint commission. He added that there was a great need for pharmacist who were trained in traditional medicine as well.

- TCAC Member Derek Valdo, National Congress on American Indians (NCAI) Southwest Area Vice President, Pueblo of Acoma, commented that the integration and collaboration in Alaska was an excellent model, but the models in the lower 48 were not the same. He mentioned that when he calls his hospital for incidence rates and data, they are unable to provide this type of information. He affirmed that Alaska had a great system in place. He noted a statistic that was not mentioned was that AI/ANs have the shortest life expectancy between diagnosis and death. He acknowledged that his point was aimed at the National Native AIDS Prevention Center, where tribes have direct access to CDC prevention funds which bypass the states. He noted that 85 percent of their funding goes to tribes that have not had direct funding themselves, which was a great way to get to new partners and providers. He asked that CDC reprioritize funding through the prevention program capacity building assistance program to support Indian country.
- Tribal Leader Sally Smith, Chairman, Bristol Bay Area Health Corporation (BBAHC), stated that she was attending the meeting as a tribal leader, but more importantly as an Alaska Native woman, mother, and grandmother; a voice for thousands of women who never get to speak for themselves. She mentioned that women were disproportionately affected by STDs in Alaska. AN women are 4 times more likely to get affected with Chlamydia than non native women. Compared to the overall U.S. population, AN women are 10 times more likely to get infected with Chlamydia. As an Alaska Native woman, mother and grandmother, she asked why native women were being infected with these diseases, and why no one is doing anything about it. She stated that the state of Alaska issued a special Epi bulletin regarding the increased incidence of Gonorrhea in Southwest Alaska. She emphasized that she represents southwestern Alaska where the Gonorrhea rates have tripled. Having an STD makes one 4 times more vulnerable to contract HIV when exposed. She stressed that the silence was supporting a perfect system to spread HIV through AN communities. AN people are overrepresented in HIV/AIDS cases in Alaska. One in four people diagnosed with HIV in 2008 were women. To date, there have been four diagnosed HIV cases in the AN community, all of whom were women. She stressed that Tribal leaders, the Tribal Health System, and CDC needed to work together to address this problem. First, more prevention programs are needed to solve this problem. She reported that the ANTHC's STD/HIV Prevention Center is the only program in Alaska addressing Alaska Native HIV/STD prevention issues. Secondly better science and better epidemiology are needed to analyze how the infections are spreading. Thirdly, tribal leaders must break the silence concerning STDs and HIV in their communities. She urged everyone to take the information presented back to Atlanta, Washington, D.C. and their communities, and put them into action to help Indian country address these disparities, and allow native women to be heard. She noted that there was a video in the lobby called "Breaking the Silence, Strengthen the Spirit," about Selena Mouse and her family living in Northwest Alaska, dealing with AIDS in their small village. Their story of courage and reliance on traditional values points the way for all native communities that face HIV and AIDS. Ms. Smith stated that in 2004, CDC funded service providers with expertise with Asian Pacific Islander, African Americans, Hispanic Latino, and Native communities to provide technical assistance and training to strengthen agency capacity to implement sustainable AIDS prevention centers. In 2009, CDC released CFDA 93.39.39, which announced dollars to fund the capacity building assistance programs for another five years. The announcement to the capacity building branch specifically announced the

priority populations being targeted by the announcement as “all individuals living with HIV and or partners, African Americans high risk populations, Latino high risk populations, Men who have sex with Men (MSM), transgender individuals, and injections drug users (IDU)”. American Indian/Alaska Native and Native Hawaiian people were excluded as a listed priority except when included with a transgender and MSM populations. The drastic departures from the practices of the previous grant cycle represents a de-prioritizing of the health and prevention needs of AI/AN and Native Hawaiian communities. This policy decision by the CDC could potentially strip Native people of their appropriate resources and services that are currently available. Indian country needs a coordinated national effort that is culturally specific, including services to Indian country such as 1) assistance to develop native specific social marketing campaigns; 2) adapting and defusing evidence-based interventions that are appropriate for native communities; 3) providing training on leadership, capacity, community assessment, mobilization, and addressing the needs of native IDU and MSM; 4) disseminate prevention information, statistics and facts related to HIV, STIs and risk co-factors that are relevant to the prevention and intervention needs of native communities. She asked for a review and revision of the decision made, and a reprioritization for the AI/AN people, and or immediate funding to support further prevention work in all of Indian country through NAPHSIS.

- Dr. Melanie Taylor, CDC Division of STD Prevention, thanked Ms. Smith for her comments and responded that the National STD Program of I.H.S. was one of the first programs that has ever taken nationally reportable data and put it into I.H.S. area data. She acknowledged the efforts of tribes in the lower 48 who have had STD outbreaks and have responded both at the community level, as well as the legislative level. She recognized Cynthia Manuel and Chester Antone for their efforts that were successful in stopping a Syphilis outbreak within their tribe, which included efforts to increase education, screenings in high schools, educating the community through local media resources such as radio, newspapers, and broadcasting their legislative council discussions, and efforts to reach out to parents to talk to their teenagers and youth about sexual health. She added that there are priorities that were put together in the National STD program, one of which was to develop a culturally relevant sexual health curriculum that could be delivered both within and outside of the school system. The program also promotes standard clinical practices that offer STD screenings as well as appropriate clinical care for native communities.
- Dr. Tom Hennessy, Director, Arctic Investigations Program, added that AIP works in close collaboration with the ANTHC, where the principal concerns they have partnered on was the problem with pneumonia among Alaska Native children. AIP has been able to highlight some of the risk factors, especially lack of having running water in homes of rural Alaska, which is a principal predictor of whether a child will be hospitalized or not. AIP is trying to find out the causes from a social determinants perspective, as well as what those infectious diseases are. There are limited diagnostic capabilities in hospitals in rural Alaska, and they have been able to augment with newer molecular DNA or RNA testing methodologies, and understand more about the broad spectrum of respiratory infections that are causing this. They hope this will lead to an increased activity in development of water and sanitation systems, as well as other options as they develop new vaccine tools. He added that AIP tries to provide a voice for policy recommendations that are specific to AI/AN children in the area of vaccination.

- Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion, CDC, stressed absolute urgency on the part of federal agencies to work together more effectively. She noted that even with HRSA providing title five funds, CDC conducting research and surveillance work on MCH, the Tobacco Program implementing tobacco cessation, I.H.S providing resources and expertise, they are still not as coordinated as they need to be across the three federal agencies to provide support to Indian country in the MCH area. She also noted how important it was to look across the spectrum of services for intervention. To have adequate impact, the prevention programs need to be completely integrated with clinical programs, and the clinical programs have to be integrated with the state programs. This is another example of how CDC should be working diligently to ensure that the state programs that they support are working with the tribes and tribal consortiums.
- Dr. Stephanie Bailey, Office of Public Health Practice, CDC, asked how are the tribes best using the resources. Is tobacco going out in the community? Is MCH going out? Is each program going out in silo as the money comes or are tribes trying to use the resources as efficiently and effectively as you can? She also mentioned that she did not want to leave Sally Smith's plea concerning NAPHSIS off the table. She stated that she had an opportunity to talk to several people concerning NAPHSIS and the funding that was lost, particularly related to AI/ANs. Dr. Bailey stated at the minimum Ms. Smith deserved an answer from the center regarding why that priority changed with this year's funding. She indicated that she would ensure Ms. Smith received an answer. And then from the answer, the negotiation process could be started.

CDC Tribal Related Issues and Working Lunch

Moderator

Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health

Dr. Bryan welcomed the group to the working lunch session. He indicated that CDC staff would be sharing information, data, and possible projects across a spectrum of public health issues during the session. Dr. Bryan introduced the first presenter, Dr. Tom Hennessy of the Arctic Investigations Program, who would be sharing activities currently being conducted by AIP in Anchorage, as well as presenting information related to dental caries.

CDC Arctic Investigations Program – Program Highlights/Dental Caries Outbreak

Dr. Tom Hennessy, Director, Arctic Investigations Program

Dr. Hennessy gave an example of an Epi Aid in which one of their tribal health partners in Alaska sought input and support from CDC for a particular problem. An Epi Aid is meant to mobilize resources from CDC and other sources to address a pressing public health need either in a state or locality.

AIP is CDC's field station for infectious disease in Alaska. Its predecessor dates back to 1948 with the Arctic Health Research Center. Since 1973, CDC has operated this field station in conjunction with the Alaska Native Medical Center. He stated that AIP sees itself as very integrated in the health care system in Alaska. This request for assistance came from their partners at the Yukon Kuskokwim Health Corporation in August 2008. They were aware of

issues of high rates of full mouth reconstruction among children around the age of six. They noticed that they had conducted 400 of these procedures in 2008; their entire birth cohort for the area was 600, so approximately two thirds of their birth cohort was having a full mouth reconstruction. They saw this as evidence for an ongoing problem, and a failure in dental public health and asked for assistance. A full mouth reconstruction is a procedure that is performed under general anesthesia that includes multiple extractions of decayed teeth, and then restorations, either fillings or crowns. Children after these procedures would often have metal teeth. Dr. Hennessey stated that this has almost sadly a rite of passage in rural Alaska that children get this at a certain point in time entering school. He added that when this many teeth are taken out, it clearly represents a failure to prevent dental caries.

Dr. Hennessey explained that dental caries are cavities, an infectious disease. He reported that dental caries was a destruction of the outer surface of the teeth that could take on several forms such as untreated decay, and missing or filled teeth. Besides the obvious cosmetic issues, there are other effects of having dental decay in children which include persistent pain, decreased weight and height development, and impaired speech development.

The Yukon Kuskokwim Health Corporation is southwestern Alaska. It is about the size of North Dakota and comprised of about 52 villages with approximately 25 thousand people, 85 percent of whom are Yup'ik Eskimo. The region only has one regional hospital located in the town of Bethel where there are four full time dentists, as well as part-time traveling dentists. They are chronically understaffed for their dental providers and experience many difficulties. He stated that many YKH villages average approximately 300 to 600 people. The communities are very remote with no road systems that connect the villages; therefore to get from one village to the other requires travel by plane, boat or snow machine. This region has the largest challenge in Alaska for delivery of in home water and sanitation services; 42 percent of the villages in this region do not have running water or served homes. Being able to provide fluoridated water is extremely difficult to do when there is no running water in the villages.

Dr. Hennessey presented data that showed that less than one percent of people historically in Alaska had dental caries. There was a study conducted in the 1920's that showed that caries rates among Alaska Native people were among the lowest in the world. The traditional oral health of Alaska Native people was actually excellent. Improved transportation and dietary changes led to problems in dietary issues. A study conducted in 1984 by I.H.S. showed that dental caries among children in rural Alaska were two times higher than the U.S. population. A repeat of that in 1990 showed that the vast majority of children had dental caries.

When AIP was asked to investigate this problem, there were two simple objectives. The first objective was to describe dental caries in the YKHC region to determine how common and severe the problem was. The second objective was to determine risk factors for dental caries. AIP examined children in five villages based on whether the villages had fluoridated and non-fluoridated water. They then conducted oral exams on children at the village schools. All children between the ages of 4 to 15 year old were invited to participate with parental consent. Overall, AIP enrolled 348 children.

He reported that AIP also implemented an Oral Health Survey of the parents of the children where they asked questions regarding the practices related to oral health such as "how often does your child brush their teeth." Additionally, parents were asked questions pertaining to their knowledge regarding oral health such as "is it okay to put a baby to bed with a bottle." Lastly, parents were asked questions pertaining to their attitudes related to oral health like "I can improve the health of my child's teeth."

Through their study, the AIP discovered that the number of dental caries in primary teeth of children in the YKHC region was much higher compared to the U.S. average. Overall, the rates of caries in the children were two to five times higher than what is seen in the general U.S. population. The results also showed that children living in villages where fluoridated water was available were much lower, and much higher rates for those children living without fluoridated water.

Dr. Hennessey stated that a major part of the goods transported to rural communities includes soda. There is a high degree of soda consumption among children in rural Alaska. Soda contributes to the development of dental caries, as well as other issues. The two main risk factors for dental caries is not having fluoridated water, which increased caries by three times. Data revealed that each soda consumed increases caries by .30 percent. AIP concluded that YKHC children have severe dental caries two to five times higher than the total U.S. population, and that the lack of water fluoridation, and the problems with water service delivery contribute to dental caries severity.

AIP recommended that YKHC fluoridate their water systems, expand the use of fluoride varnishes or sealants to help protect children, decrease soda consumption, address unmet dental needs, and to establish ongoing surveillance and program evaluation. Dr. Hennessey noted that the YKHC dental caries issue was a massive problem. He noted that the Epi Aid mechanism was not meant to establish a program and solve all of these problems quickly. Its purpose was to highlight the problems, offer recommendations, and build a relationship between AIP, YKHC providers, CDC and I.H.S. Dr. Hennessey acknowledged a few of the partners participating in the Consultation Session; Dr. Bill Kohn, Division of Oral Health, and Dr. Sarah Shoffstall, ANTHC Dental Program. Dr. Hennessey stated that all data was reported to YKHC senior leadership. AIP and its partners hope to develop an ongoing relationship to address these problems, and assist them and follow their lead in the directions that they would like to go to solve the problems; and hopefully bring resources from CDC and elsewhere to think about comprehensive approaches that could be used across the state, as well as on a national scale.

Questions

- Vice-Chair Rose (did not provide last name) commented that her mother lived next to a well during the 1980s where the village water system was fluoridated. She stated that the well malfunctioned, which caused the death of her cousin, and almost killed her mother and sister. She stated that her family filed a lawsuit and won their case. She asked how could this type of problem be prevented in villages in the future. Additionally, she stated when companies have to get rid of large amounts of fluoride; it must be labeled as a hazardous waste.
- Dr. Hennessey affirmed the occurrence as a tragic event, one that should definitely not be repeated. He responded they have made some improvements in recognizing the risk of fluoride toxicity, and there have been recent innovations that may allow them to evaluate fluoride levels in rural villages in a more effective manner. To put fluoridation in a village system in Alaska requires a trained village water operator, and there are CDC recommendations for monitoring and guidance related to that. At ANTHC, some of the engineers have developed a system for remote monitoring of fluoride levels in water in the villages, and then transmit the readings back to one of the ANTHC engineers. So if the levels are going up, if the engineers catch it, they can turn the levels down. If they do not catch it, the system will allow a remote monitoring so that someone in Anchorage

could evaluate the problem. Dr. Hennessey stated that they were hopeful that those systems, along with increased vigilance regarding water fluoridation will allow them to use that technology to make the process even safer than before.

- Vice-Chair Rose asked if the system was in place in the villages to date.
- Dr. Hennessey replied that the system was currently being tested in several communities, and that the ANTHC Environmental Health staff was moving forward with the program.
- Vice-Chair Rose commented that ANTHC should go to the villages to make sure that the tribal people are trained to use these fluoridation systems. She stressed that if something bad happens, the computer monitoring system will not be able to save the tribal people. She emphasized that one life had already been taken and that she did not want to see others die from the same mistakes.
- Dr. Hennessey thanked Rose for her comments and stated that the training component was critical. He noted that it was an important function of the Sanitarian's job to maintain training and competencies, and it is an important aspect of the responsibility of providing safe water in communities.

Update on STDs in Indian Country

Dr. Melanie Taylor, Division of STD Prevention

Dr. Taylor welcomed the group and stated that she would be presenting sexually transmitted disease information among AI/ANs on a national level. She reported that Chlamydia was the most commonly reportable bacterial infection in the country. There were more than one million cases reported in the year 2007. She noted that if cases were evaluated by race/ethnicity, AI/ANs represent the second highest risk group. As a group, young women are the primary population that bears the greatest burden. The I.H.S. area that bears the highest burden of Chlamydia is the Alaska area.

She reported that African Americans were overrepresented in Gonorrhea rates. The second highest race/ethnicity groups for Gonorrhea are Hispanics, and AI/ANs follow in a close third. The I.H.S. area that bears the highest burden of Gonorrhea is the Alaska area, followed by Tucson, Aberdeen, and Phoenix.

Dr. Taylor stated that Primary and Secondary Syphilis were the most infectious periods of Syphilis transmission. AI/ANs are the second highest risk group. Males rate higher in infection than females, primarily driven by the outbreaks and rates of Syphilis being driven by men who have sex with men (MSM). Dr. Taylor mentioned that the Tohono O'odham Nation experienced a very large outbreak of Primary and Secondary Syphilis in 2007 and 2008 that drove the rates of Syphilis to be the highest for 2007. Along with the outbreak of Primary and Secondary Syphilis in Tohono O'odham were two other increases of Primary and Secondary Syphilis in two other tribes.

Dr. Taylor stressed that there needed to be integrated response. The response to STDs cannot just come from the community level; clinical services also needed to be integrated through the educational practices provided to the youth because they the highest at risk. The rationale is

that STDs occur disproportionately among AI/AN populations nationally, youth are disproportionately affected across all race/ethnicity groups, particularly more with AI/ANs. Additionally, prevention of infertility and atopic pregnancy, outbreak potential, and clinical quality of care standard within healthcare systems are key rationale for STD response capacity.

She noted that Chlamydia screening needed to be provided annually for all sexually active women 26 years old or younger. In addition, those women who are diagnosed with Chlamydia should be offered the opportunity to be rescreened since re-infection rates are so high. In 2009, the recommended specimen for diagnosing Chlamydia and Gonorrhea was the self-collected vaginal swab, which is important for clinical providers to recognize as a way to get past confidentiality issues associated with STD testing. Alaska is currently working to make the self-collected swabs available for both men and women to overcome the confidentiality barrier regarding seeking care at the village level. She emphasized that appropriated, presumptive treatment of patients and partners was critical for preventing outbreaks. Expedited Partner Therapy (EPT) is one of the most important ways to ensure that partners of patients receive therapy. Finally, appropriate immunizations are key to clinical response as well.

STD prevention programs must create, maintain, and utilize, plans to rapidly detect and respond to outbreaks. Outbreak plans should include careful and ongoing assessment of disease trends, establishment of disease thresholds, mobilization of resources, and efficient communication with the affected community. Outbreak detection involves reviewing the standards for the surveillance system, and developing procedures for the accurate and timely analysis of data gathered.

Dr. Taylor acknowledged the success of the outbreak control of Tohono O'odham Nation that was heavily influenced by the effective collaborations between the tribes, HHS, their legislative branch of government, the state and county health departments, and CDC. There had been more than one hundred cases of Syphilis diagnosed in the tribes, six cases were unfortunately congenital Syphilis, or infants born with congenital Syphilis; two were still births. She noted that as of May 2009, there have been no further cases of Syphilis diagnosed. The collaborative response included a school education program, and a school-based screening program in six high schools within the tribe. Comprehensive STD screenings of Chlamydia, Gonorrhea, HIV, and Syphilis, followed by comprehensive, culturally relevant sexual health education, as well as local media resources were also used. In addition, the I.H.S. implemented broad screenings and was able to detect a huge number of cases.

She highlighted a web-based education program that was developed Jessica Leston, a website that delivers culturally relevant sexual health information to Alaska Native youth called www.lknowmine.org. She emphasized that culturally relevant education that was internet based is very important for sexual health education. Dr. Taylor also stated that it was imperative that comprehensive sexual health education that is evidence based be incorporated into the school systems.

The goals of the I.H.S. National STD Program are to raise awareness, support partnerships, improve programs, increase access to trainings, improve surveillance, promote research, support outbreak response and encourage service integration. She added that the program has had a very successful collaboration with the Alaska Native Tribal Health Consortium since 2006. As a result, an STD program has been developed, and has been very effective. There has also been collaboration with Canada in addressing STDs in northern Native youth. Canada is also experiencing very similar high rates of STDs among their northern populations. As she mentioned previously, the National STD Program is the first program to take nationally reportable data and deposit it into I.H.S. service areas. This report has been updated for 2007,

and they encourage other programs that deal with chronic disease to utilize this model so that programs can have local information to guide their program practices.

The National STD Program is also known for addressing social determinates of health such as methamphetamine use in Indian country, sexual violence as it relates to STDs/HIV, and adverse childhood experiences among incarcerated AI/AN women. The program also works very closely with the National Coalition of STD Directors, which has helped them to develop the culturally relevant comprehensive sexual health education. They also work closely with Tohono O'odham Nation in implementing the Outbreak Response and Control Plan. The program has also put together guidelines for delivering and implementing STD testing in high schools. This is a program that has been adapted to tribal areas in Indian country, which was available online as a resource guide. In addition, the National STD Program put together STD Screening Guidelines for tribal jails. This is an evidence based curriculum that was adapted by tribes, and for tribes for the delivery of sexual health education to youth. It is comprehensive in that it addresses drug abuse, sexual violence, as well as sexual health promotion, STD prevention, and healthy relationships.

Dr. Taylor closed by stating that the continuing challenge and opportunity of the National STD Program is to partner with indigenous people to develop and implement innovative, effective, and culturally appropriate STD prevention and control strategies.

Environmental Public Health Programs in Alaska

Annabelle Allison, Tribal Affairs Liaison, NCEH/ATSDR

Richard Kauffman, Senior Regional Representative, ATSDR, Region X

Ms. Allison works for the Office of Tribal Affairs within the National Center for Environmental Health, Agency for Toxic Substances and Disease Registry. She stated that their focus was on environmental health issues, topics, and concerns in communities. She noted that NCEH was really known as the research arm, both in the lab and in the field for environmental health topics. They specialize in healthy homes, the EPA equivalent of indoor air quality; air pollution, respiratory health, health studies, water related to environmental health, and they also have a laboratory that utilizes innovative techniques to prevent disease from exposures to toxic chemical in the environment. Ms. Allison added that ATSDR is known for being out in the community. They are comprised of four divisions, the Division of Health Assessment and Consultation, which focuses on public health assessments, health consultations, registries in relation to emergency response issues, and surveillance; the Division of Regional Operations, the Division of Health Studies, and the Division for Toxicology and Environmental Medicine.

Ms. Allison noted that her office, the Office of Tribal Affairs, resides within the Office of Policy Planning and Evaluation. Part of her job is to work between the two agencies, NCEH and ATSDR, in a liaison type function to ensure that they are meeting the needs of tribal communities related to environmental health.

Ms. Allison introduced Richard Kauffman, Senior Regional Representative from Seattle who will talk about the work they have done in Alaska.

Mr. Kauffman mentioned that there were many concerns in Alaska related to contaminants in the environment. Mr. Kauffman stated that he wanted to share what ATSDR programs were available, in relation to contaminants, for the state of Alaska. ATSDR provides cooperative

agreement grant funding to a number of state health departments across the nation, including Alaska. ATSDR provides the programs with funding for personnel, training, travel funds, and conduct health assessment work. They have expertise in toxicology, health education, and they perform site specific public health assessment work within the program.

ATSDR recently opened an office in Anchorage. The priority areas of the Anchorage office is to site work to address hazardous waste sites in communities to ensure that people are not being exposed to toxic substances at levels which cause adverse health effects; emergency response and preparedness in which they provide assistance, trainings, and response to natural disasters and other chemical releases from spills, fires, exposures, et cetera; Brown fields, which are under-utilized, or abandoned facilities that may have a useful purpose in the future, and can be reused, with a presence of contaminants that may prohibit the reuse from occurring; Tribal capacity building to enable the communities in Alaska to address the contaminant issues and concerns without having to rely on outsiders; and health impact assessments which help to determine, in advance, what the benefits or negative outcomes of a proposed project might be through the environmental impact assessment process, and identify those areas where action can be taken to prevent adverse health impacts in communities up front.

Health Studies Branch (HSB) Arctic Health Program

Dr. Lauren Lewis, Chief, Health Studies Branch, EHHE, NCEH, CDC

Dr. Lewis expressed that the Health Studies Branch (HSB) was very excited about a new initiative that is currently being developed, an arctic health program in Alaska. The program is an environmental health program focused on addressing the environmental health issues facing Alaska natives. She solicited the group for their input and guidance as they develop the new program.

She indicated that HSB was located in the National Center for Environmental Health. They are currently developing a brand new climate change and public health program at CDC. One of the primary missions of this program is to develop local capacity to identify, prepare for, and address climate change issues.

Dr. Lewis stated that there are three primary missions of the health studies branch, one of which is to conduct planned studies to address environmental threats. HSB also investigates outbreaks of environmental and chemical origin, and are responsible for disaster preparedness and response. In addition to disasters involving chemicals, they more commonly deal with environmental disasters such as heat, cold, weather-related events, such as hurricanes and flooding.

She stated the Walker River Paiute Tribe, who had reported high levels of arsenic in their drinking water, needed to determine if it would be worth the expense to put in a community drinking water system. HSB tested the community's water sources, and took urine samples from volunteers to assess whether the tribe's exposure levels were unacceptably high. HSB found that arsenic levels were indeed high, and in fact, some members of the tribe had arsenic levels that compelled HSB to advise them to seek medical attention. The department then reported the information to the tribe, and the tribe decided to build the water system. With the assistance of HSB data, the tribe was able to get support for a community drinking water system to remove the arsenic.

Another example involved the Cheyenne River Sioux Nation in South Dakota. HSB was asked to assess the potential for mercury exposure from eating local fish. Samples were taken from tribal volunteers to measure their mercury levels, and fish consumption. Although HSB did not find high levels of mercury in tribal members, they found those who consumed more local fish had higher levels of mercury.

Dr. Lewis noted the largest study HSB has conducted was on the largest reservation in the US, the Navajo Nation. She stated that water hauling was widespread within the Navajo Nation, and roughly 14,000 households were without potable water. The goals of their study was to investigate the use of unregulated and untreated source water; investigate water storage, and handling; to determine to what extent contamination of unregulated water sources represents a public health threat; and to promote collaboration among Navajo EPA, Navajo Division of Health, Navajo Epidemiology Center, IHS, and CDC.

HSB tested 199 unregulated drinking water sources such as livestock wells, springs and natural streams. Bacteria, arsenic and uranium were found, and arsenic and uranium were concentrated in five chapters. HSB decided to conduct a follow-up study to focus on the five chapters where contaminants were most highly concentrated. To carry out the study, HSB surveyed 296 households in five Chapters with and without access to public water. Community health representatives (CHRs) visited homes, and collected information from one adult per household to document water use, hauling, and storage methods; test urine for chemical exposures in people; test drinking water in home for bacteria and chemicals; and identify additional water sources for further testing.

She indicated that HSB found a considerable proportion of households (22%) haul water, including some with access to public water. In addition, those that hauled water were more likely to be exposed to bacterial contaminants in drinking water. They also found urine uranium levels were higher than the US general population, but comparable to other Southwest populations, and below levels known to cause health effects. Also, water contamination did not appear to be the sole source of uranium or other chemical exposures found in Navajo population.

HSB has also implemented an Arctic Health Program, where the branch funded discrete long term studies to investigate environmental exposures and health. New approaches include building capacity for environmental epidemiology through staff development, implementations of environmental health projects, and providing expertise and strengthening relationships. Initial areas of focus for the program included drinking water issues, and climate change; however, the branch is interested in soliciting the Tribal organizations to provide insight into additional environmental health focus areas to consider.

Discussion Points

- Tribal Leader Ching King, Ft. Belknap Indian Community, commented that his concern across the country was poor mining practices, military ordnance, bombing ranges, nuclear waste, et cetera on Indian reservations. He wanted to know why the DOD and other related organizations were not being held responsible. In addition, he asked if CDC/ATSDR could conduct studies to show why AI/ANs in these areas have such high rates of cancer.
- Dr. Lauren Lewis, Chief, Health Studies Branch, CDC, responded that ATSDR was working on a similar issue. They have been giving funding to evaluate exposure to

uranium from mining, and rates of disease and other health outcomes near the mining. This study is being conducted in Navajo Nation. She added that there were approaches that ATSDR could take to help address these type issues and provide information.

- TCAC Member Jim Crouch, Executive Director, California Rural Indian Health Board (CRIHB), asked where does the response for these type issues come from.
- Richard Kauffman, Senior Regional Representative, ATSDR, Region X, replied that there were regional offices across the country that could respond to issues very specifically.
- Dr. Stephanie Bailey, Office of Public Health Practice, CDC, explained that there are legitimate questions that emerge from communities that need to be addressed in a research format, noting that response needed to be the key priority. She stated that there were too many questions that CDC was missing from community processes. She asked Ms. Allison if there was a place that requests for research could come in directly. She emphasized that CDC was working diligently to incorporate bidirectional translational effectiveness and research into current practices.
- Annabelle Allison, Tribal Affairs Liaison, NCEH/ATSDR, replied that the response really depends on the contaminants in question. She stated that it also depends on if the concern is related to cancer, or some other health topic. Taking that information, ATSDR can identify the appropriate division to respond to your particular concerns. She mentioned that it was also helpful to have data, or to know if previous assessments have been conducted in the past.
- Tribal Leader June Walunga, First Vice-Chair, NSHC, stated that their villagers were dying from suicide and cancer. She reported that two villages were used as a military defense sites many years ago. She indicated that they contacted DOD to conduct a cleanup of the left over ordnance. She noted that DOD came out to the villages to clean; however, nothing was cleaned under the surface. Ms. Walunga mentioned that her tribe even contracted with engineers to perform the clean up themselves. She emphasized that there was left over ordnance underneath homes and schools, as well as toxic waste and contaminants. She stated that her community took the issues to both the regional and state level, but still have not received a response. She mentioned that when her tribe notified the environmental agencies, they did not get a response either. Now DOD has informed them that they will no longer fund additional cleanup efforts. Ms. Walunga commented that in WWII, the military used their land, and made themselves at home. As a result, they have very high rates of cancer, and are slowly dying. She pleaded with CDC to help her tribe.
- Richard Kauffman, Senior Regional Representative, ATSDR, Region X, responded that this was a very common concern that many communities across Alaska have. He noted that there were around 700 formerly used military sites, and they the issue was an extraordinarily complex one that CDC, ATSDR and the tribes were attempting to work out together. He stressed that CDC was there to work with tribes to address their concerns.
- Dr. Stephanie Bailey, Office of Public Health Practice, CDC, added that CDC was presently developing agendas to discuss priority concerns with other departments and

organizations since some of the issues being reported were outside the scope of CDC capabilities.

- Annabelle Allison, Tribal Affairs Liaison, NCEH/ATSDR, agreed with Dr. Bailey's response and stated that this was definitely an area that will require collaboration alongside sister agencies, the DOD, EPA, I.H.S. and the Bureau of Indian Affairs. She noted that EPA was the regulatory arm for environmental protection, standards, compliance and regulations. She commented that ATSDR was strong in conducting the assessments, but noted that they needed to connect the bridge between the data and protecting human health. She agreed that these type discussions needed to take place with Secretary Sebelius and Yvette Roubideaux as soon as possible.

National Focus Areas

Moderators

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

Focus Area #1: H1N1 Preparedness and Response and SNS

Chester Antone, Tohono O'Odham Legislative Councilman and TCAC Co-Chair

Joe Finkbonner, Northwest Portland Area Indian Health Board

Cynthia Manuel, Tohono O'Odham Legislative Councilwoman

Mr. Antone reported that on July 23, 2009, his tribe submitted a position paper regarding border issues, and the possibility of disease impending across the border. He stated that recently, his tribe reported an occurrence of an illegal immigrant that was encountered in the dessert, and eventually transferred to a regional hospital in Casa Grande, a border town. As a result of this encounter, Tohono O'Odham was immediately notified of the potential to investigate H1N1. Mr. Antone indicated that border issues have been a concern within his tribe previously reported to CDC during 2007 Consultation Session. He petitioned CDC for immediate assistance, as an international voice, to take the lead to identify partners and establish a forum that could address these issues.

Mr. Finkbonner emphasized that H1N1 was categorized as a Level 6 Pandemic Flu. He mentioned that as the fall approaches, he hopes to apply lessons learned to better mitigate the impacts on tribal communities. He stated that 80 percent of public health deals with relationships that are developed with partners, which he noted plays a huge role in the mitigation efforts that take place. Along with that, he acknowledged that even the best plans have problems, and even the best relationships do not always result in the best outcome. He referred specifically to the antiviral distribution through the SNS distribution system, which did not work well through some of the tribal communities. This was due to SNS distribution going to the states, and then the states disseminating the vaccines through their Pandemic Flu plans. In some cases, this meant that vaccines were distributed to local pharmacies, and then the pharmacies would take prescriptions from the providers, and then the patient was given the antiviral for treatment. He noted the problem is that most tribes tend to be rural. He stressed that Walgreen's, Wal-Mart's, or Rite Aids' did not exist on most reservations. Therefore distributing H1N1 vaccines to local pharmacies could mean being two hours away from the

nearest reservation or tribal clinic. He suggested that CDC rethink the tribal SNS distribution system.

Mr. Finkbonner noted that the initial H1N1 communication was very good, but stressed the importance of learning from past mistakes to enhance distribution for the fall. He implored all parties to collectively develop materials that could get to the community level, besides the fundamental messages like wash your hands, cover your cough, and get your vaccine shot as soon as possible. He stressed the importance of educating people regarding the high risk populations, getting seasonal flu vaccines to community members, antiviral resistance, and vaccine shortages. He noted that it was important to develop intervention plans to identify the number of doses needed, and how the vaccines would be administered in order to minimize the impacts on tribal communities.

CDC Respondents

Dr. Jay Butler, Influenza Coordination Unit, CCID

Mr. Rob Curlee, Deputy Director, Financial Management Office (FMO)

Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health

- Dr. Butler stated that he believes H1N1 planning has really paid off and that failures were related to where planning has not taken place as adequately as possible. He agreed that communication of H1N1 information was good, and that there was not as much panic as there could have been. He noted the challenge that lies ahead are messaging that surrounds the vaccine. Dr. Butler indicated that there are many misconceptions such as the vaccine being experimental. He noted that the vaccines were not experimental, and that it was the same type of process that was used to make their seasonal vaccine, except that with a new Influenza strain that is being incorporated in it. Another misconception is that people believe that the government is forcing everyone to take the vaccine. Dr. Butler noted that H1N1 was not a mandatory program. The goal is to make the vaccine available to people who desire to be immunized. In terms of vaccine supply, the government has purchased over 195 million doses, with the option to purchase more. He commented that he felt good about the investment in supply as long as the process of manufacturing and distribution goes well. He reported that the process of how federally purchased vaccines are distributed was decentralized a few years ago. Vaccines For Children (VFC), for instance, distributes vaccines through a centralized vendor directly to providers; which will be the approach for the H1N1 vaccine. This program will be implemented by the states.
- Joe Finkbonner, Northwest Portland Area Indian Health Board, asked if two doses of the vaccine would be given, and if so, how far apart.
- Dr. Butler responded that two doses would be given. The reason it requires two doses is if a person has never been exposed to a related Influenza virus in the past, people do not get a very good immune dose the very first time. Additionally, the two doses will be administered 2 to 3 weeks apart.
- Dr. Bryan added that a workgroup comprised of CDC, I.H.S., tribal leaders and other experts were in the process of trying to develop a guidance document to speak to the SNS distribution process on antivirals and tribal rights. It will speak to the vaccine distribution process and the importance of tribal, state and IHS planning and

collaboration. It will also speak to the funding distribution streams, which is similar to the public health preparedness funding. It will have a Q&A section based on questions CDC has received from state and tribal constituents. When the document is packaged, it will be posted to the CDC website, and distributed to everyone involved in Indian country.

- Rob Curlee, Deputy Director, Financial Management Office (FMO), noted that there was a large amount of funding that the government has set aside for the planning and preparation of H1N1. Approximately 7.6 billion dollars has been set aside, which he noted would be distributed in portions. Recently, CDC received 200 million for Epi services towards domestic preparation operations, vaccine distribution planning and start up processes. In addition, 350 million was administered to state and local hospitals. Other amounts went towards vaccine development. Mr. Curlee stated that there was also 1.8 million dollars in Emergency Contingent Funding set aside if the President determined more funding needed to be provided for pandemic activities and public health emergency response. He emphasized that CDC was working diligently to expedite the federal process to move the funds out as quickly and efficiently as possible.

Focus Area #2 – Health Reform, ARRA, and CDC Budget Priorities

Derek Valdo, Pueblo of Acoma, NCAI Southwest Area Vice President

Jim Crouch, Executive Director, California Rural Indian Health Board

Evelyn Alcothley, Navajo Nation, Health and Social Services Committee

Mr. Valdo commented that because of lack of insurance and other options, I.H.S. was the only system available to many tribal systems. Mr. Valdo stated that NCAI supports the current Senate version of the Health Reform Act because it preserves the I.H.S. system. He added that AI/ANs were the only group that has an entitlement to health care. He acknowledged that the Indian Health Care Reform Act should be passed, which would improve the current I.H.S. system. In terms of ARRA funding, they would like to see tribes included as eligible entities to gaining access to resources. In terms of budget priorities, Mr. Valdo noted that NCAI wanted to see tribal set asides.

Mr. Crouch emphasized the need for everyone to support national health reform, and shared two significant concepts within the House Health Reform Bill (HR3200) that was germane to the entire population. He highlighted the High Quality Home Visitation Program for pregnant women or families with kids, which would become an optional benefit under Medicaid. This program would pay for a large amount of CHR work if the states chose to implement it as an optional benefit. Additionally, he noted available grant funding from the Agency for Children and Families (ACYF), is in place to establish the capacity to carry out those programs. He stated that the tribes would have a set aside opportunity under the program. Moreover, there would be five percent of the money set aside for training and technical assistance. Mr. Crouch stressed that this was a unique moment in American history because country has another chance to change access to basic health services. To the extent that the Federal Indian Health Service is underfunded at about 50 cents on the dollar, he noted that it behooves everyone to become very engaged in a national health reform conversation in hopes that there will be better access for citizens.

Ms. Alcothley reported that in July 2009, like many Indian Tribes and National Indian Organizations, the Navajo Nation submitted a response to Senator Byron Dorgan regarding his concept paper on reforming the Indian health care system. The Navajo Nation has consistently

supported amendment and enhancement of the Indian Health Care Improvement Act. Reauthorization and full funding of the Act will modernize and improve Indian health care and delivery of services to address the most grievous health disparities of AI/ANs. The 2003 U.S. Commission on Civil Rights report indicated that “the federal government’s rate of spending on health care for Native Americans is 50 percent less than for prisoners”. Reauthorization alone is insufficient! Therefore, full funding and making the Indian health Care Improvement Act permanent will be a true health care reform. While CDC and ATSDR are developing strategies, it must seriously consider their past and present recommendations. The Navajo appreciate the progress that the CDC has made working with tribes over the past several years; however, there is room for improvement to continue building on and strengthening communication and partnerships. One way to assure that this occurs is that an Office of the American Indian and Alaska Native be established and adequately funded within the Office of the Director at CDC.

Ms. Alcothley stated that the Navajo appreciates the opportunities that ARRA brought to Indian country. The Navajo area has received ARRA set aside funds. They are currently working to transform the existing Navajo Division of Health to the Navajo Department of Public Health. The Navajo Nation’s council will be considering legislation this fall to achieve the scope. Meanwhile, they are faced with the huge challenge which is lack of trained public health workers. They are unable to provide adequate training to prepare current and future employees to appropriately staff the new Department of Public Health. The Navajo Nation requests the support from CDC to utilize the ARRA funding to help train employees, and to provide technical assistance for many of their current and planned public health projects.

Ms. Alcothley briefly spoke about the Navajo Nation’s experience with CDC funding for public health preparedness and response. She stated that the Navajo Nation receives a portion of the ten percent set aside for the tribes as compared to 67 percent to the counties when the Navajo nation is larger or equal to half of the counties. In addition, every grant award received from the Arizona Department of Health Services has been late and has created a limited spending period. Thus, the spending pattern appears to be rushed and sporadic.

In terms of budget priorities, Ms. Alcothley reported that at the November 2008 CDC/ATSDR Tribal Consultation Session, Navajo Nation representatives recommended the CDC and ATSDR to include adequate levels of funding consistent with the federal government’s coordinated five-year plan to carry out eight objectives created in the Waxman Congressional hearing in October 2007. At that time, the Navajo Nation urged CDC and ATSDR to be key partners by supporting a long-term comprehensive assessment and research program with adequate personnel and resources.

The tragedy of uranium mining on the Navajo Nation has caused much pain, suffering and death. The devastating effects on human health and environment still remains. The Navajo Nation requests CDC and ATSDR to include adequate funding level for a comprehensive study in its budget. Ms. Alcothley requested, on behalf of the Navajo Nation, for CDC to support the Navajo nation Action Plan for H1N1 Preparedness and Response which will cost \$945,000 to adequately implement the plan.

CDC Respondents

- Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion, CDC, agreed with the comments made, particularly regarding the opportunity to witness substantive change in the health system. She noted one of her most pressing concerns was

ensuring prevention in public health activities remain in the legislation. She emphasized that it was essential that AI/AN issues be a critical part of health reform. In addition, she reaffirmed the need for CDC grant priorities to be addressed. Dr. Toomey remarked that a critical transformation process was taking place within CDC. She held that one of the key prospects of this consultation is an opportunity for CDC leadership to convey AI/AN issues to the Director during a time that in which he is reassessing his priorities. Additionally, the Health Research Services Administration has funding specifically for public health workforce training, and CDC will obtain more information regarding how to access those funds to increase workforce capacity at the tribal community level.

- Dr. Stephanie Bailey, Office of Public Health Practice, CDC, agreed with Dr. Toomey and stated that it was more unique for the AI/ANs to capitalize on the reform that is taking place. She mentioned that because they understood that prevention was critical, and that I.H.S. has a clear mandate to address health care, Indian country has a unique opportunity to reform, create, and implement a health system. She invited an elected group of tribal leaders to engage in talks with CDC regarding health system reform.
- Rob Curlee, Deputy Director, Financial Management Office (FMO), stated that there were a number of things occurring with CDC in terms of budget priorities. He acknowledged that the new director was strategizing in a number of areas which includes monitoring the health of the nation and the impact of health reform; public health works which includes expanding EIS officers, building up training and workforce; strengthening the evidence base and practice of prevention; ensuring safe and healthy U.S. bound refugees; healthy food and water; and preparedness grant area planning for 2010. Mr. Curlee stated that he would go in more detail during the TCAC meeting.

Focus Area #3 – Tobacco –Related Health Issues and Building Healthy Communities

Kathy Hughes, Vice Chairwoman, Oneida Business Committee,

Bemidji Area and TCAC Co-Chair

Corrine Garbani, Council Member from Pechanga Band of Luiseno Indians

Ms. Hughes reported that Wisconsin has a Healthy Wisconsin 2010 Plan to protect and promote the health of the people of Wisconsin. She noted that there was a component of the plan that dealt with tobacco use and abuse. Their focus was on youth prevention, sixth to twelfth grade. According to the 2000 report, 16 percent of the sixth graders that completed the survey admitted to using tobacco. This figure went down to 13 percent in 2004; however, of that 13 percent, 26 percent were AI/ANs, which represented the highest category. The Great Lakes City Tribal Council conducted another survey in 2008, which is currently being completed this year. In this survey, the council concluded that they reached approximately 90 percent of the youth, grades sixth through twelfth for the 11 tribal communities in the state of Wisconsin living on and off the reservation. Ms. Hughes acknowledged that she did not have the final statistics from the survey, but is hoping that the results have decreased.

She indicated that the state of Wisconsin recently approved a state-wide smoking ban that will go into effect January 2010. They also have one of the highest tax rates for tobacco products. Last year legislatures passed an additional \$2.25 tax on tobacco products. With the approval of the new budget, there will be another tax increase of \$.75 per pack of cigarettes. She noted that it was beginning to be extremely expensive for smokers in the state. Ms. Hughes commented that her tribe banned smoking in their facilities 20 years ago. She believes that smoking cessation will improve health related issues within her tribe. She asked CDC to

provide better communication of information; especially for the youth, with an emphasis on prevention. She added that since tobacco use was a traditional part of Indian country, she stressed culturally sensitivity of the use of tobacco not be denigrated. She encouraged CDC to communicate the differences between commercial use versus the cultural use of tobacco.

Ms. Garbani stressed that tobacco related health issues were prominent in her region. She reported that the programs that have been implemented in California have centered on prevention. Because California is a CHS dependent state, the continuum of care is extremely limited. She noted that they could only provide front line services in their clinics, therefore having to refer patients out to private providers for in-patient and specialty care. She mentioned that often times patients get lost into the system and they are not able to follow them through the continuum of care. She stated that one way to address this problem is to encourage prevention.

The state of California has the Tobacco Education Prevention Technical Support Program (TEPTS), which is run by the California Rural Indian Health Board (CRHIB). Ms. Garbani noted that even with limited funding and limited staff, the program has been very effective. The program provides technical assistance and capacity building for health programs across the state. In addition, they conduct "train the trainer" programs, as well as many grant programs that produces various events to distribute tobacco education materials. She solicited CDC to assist to help them increase the capacity of those programs. They have a need for public relation experts, different mediums of communication, and training, which will help the program to improve the quality of their services.

Additionally, Ms. Garbani stated that California has two consultants at the I.H.S. area office, who are funded out of the homeland security dollars for infectious disease prevention and control. They focus on prevention, management, and response of fires and outbreaks of diseases. However, they do not have anything in place for prevention of infectious diseases. She requested CDC technical assistance support to help respond to these issues.

CDC Respondents

- Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion, CDC, pointed out that tobacco was the leading cause of preventable death among AI/ANs, and for the nation as a whole. She affirmed that this was a critical prevention issue. She commented that her sister was a two pack a day smoker and suffered a preventable stroke at age 48. She added that the points raised by the tribal leaders were good messages for CDC. She noted that prevention issues are difficult to address when gaming and cigarette sells are a critical parts of tribal revenue. Additionally, second hand smoke ordinances are perceived to undermined revenue generation. She affirmed that this was a problem a major problem that warrants assistance, which CDC was happy to provide. CDC needs to be conscious of the unique policy issues Indian country faces. Yet there is clear evidence base of the impact of prevention of second hand smoke policies, children, asthma rates, et cetera that simply cannot be avoided. She stressed as they move forward, to embrace a culturally sensitive approach to tobacco cessation and prevention.
- CDC's Office of Smoking and Health has a small program called the Tribal Support Centers, which improves the capacity to conduct culturally specific tobacco control and prevention in tribes, and to develop culturally appropriate media campaigns for tribes. Six tribal organizations currently are funded.

- Tribal Leader Ching King, Ft. Belknap Indian Community, noted that in addition to cigarette smoke, industrial pollution causes respiratory illnesses among AI/ANs as well.

Open Tribal Testimony

- Tribal Leader Corrine Garbani, Pechanga Band, reiterated how critical NAPHSIS funding is to AI/AN communities. She stated that NAPHSIS provides funding prevention services for HIV and AIDS in their communities. She stressed taking those funds away would drastically affect the AI/AN community. She reported that Riverside County has the sixth highest rate for HIV cases, and the fifth highest for AIDS cases in the state, thus showing how critical the need for NAPHSIS funding in AI/AN communities.
- TCAC Member Byron Jasper, United Southeastern Tribes (USET,) stated that one of their tribal leaders, Chairman Buford Roland, who also serves as Vice-Chairman for the National Indian Health Board, Co-Chairman of Tribal Leaders Diabetes Committee, and is also Co-Chair of the National Steering Committee for the Reauthorization of the Indian Healthcare Improvement Act; has been an advocate for Tribal Epi Centers and their need to access data so they can assist tribes in building community health profiles, and health reports. The purpose is to assist tribal leaders to make better informed decisions about health disparities affecting their communities. He stated that he was pleased to present testimony on behalf of Chairman Buford Roland:

Chairman Roland respectfully requests the CDC to initiate a long term federally funded program that will develop and maintain a unified system for linking I.H.S. tribal and urban data to state and federally maintained national vital statistics systems, especially birth and death data; state and federally maintained notifiable disease surveillance systems and other critical disease and injury data surveillance systems. And to increase AI/AN sample sizes in current and future HHS health surveys and disease and injury surveillance systems to allow valid and reliable tribal specific population estimates.

As the country undertakes health care reform, assurance of adequate data for all segments of the U.S. society is needed for policy development and program implementation. Health care 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 health disparity populations. The need for improved data on American Indian subpopulations, whether defined geographically, or some other characteristic, requires adaptive data collection standards, methods, and analytical techniques. While several current survey mechanisms can develop estimates for AI/AN subpopulations, the sample size are not sufficient to adequately assess and report the health of AI/AN people, especially the small populations and fairly recognized tribal groups. Often times any attempt to develop population estimates about small AI/AN subpopulations based on these numbers are seriously flawed. The multiplicity of factors that contributes to health disparities requires enhanced availability of AI/AN data that is truly representative in a collective 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 or 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 21 century are to be adequately measured and addressed.

Under the Indian Health Care Improvement Act, the CDC Director is to ensure CDC assets provide technical assistance, and work closely with tribal Epi Centers. In strengthening AI/AN disease surveillance, because many tribes and Tribal Epi Centers do not have necessary resources and know how to maintain a steady and focused effort to gain linkable, accessible access to a multitude of health data systems. AI/AN communities are hindered in obtaining data and analysis help them solve their health disparity issues.

Similarly, because many tribes and Tribal Epi Centers are not positioned with the National Public Health Infrastructure that designs and coordinates national health surveys and data collection efforts to properly advocate to increased AI/AN sample size. Samples continue to be implemented that do not have adequate AI/AN sample sizes for critical epidemiological analysis and health reports.

Chairman Roland believes that CDC technical expertise, its special partnerships with every U.S. state health department, its lead role in steering most, if not all of the country's public health surveillance systems that the CDC is ideally suited to lease the HHS wide initiative to better assist and empower the National Network of Tribal Epi Centers and tribal governments that they serve to improve the coordination and the enhancement of AI/AN data collection and linkage and analysis. Chairman Roland calls upon the CDC Director in partnership with the U.S. Secretary of HHS to form a true and well supported alliance directly with Tribal Epi Centers, and their tribal constituents, to develop a sustainable, 21st century health information technology enhanced AI/AN disease and injury surveillance system focused intently on better measuring and communicating health disparities in AI/AN.

In summary, Chairman Roland requests CDC's assistance in mobilizing a long term federally funded program to develop and maintain and unified system for linking I.H.S. and tribal and urban data to key sources of data and to modify sampling frames of existing and future national health surveys for the purpose of enabling the tribes and Epi Centers to better monitor the health status of AI/AN people.

- TCAC Member Jerry Freddie, Navajo Nation, Council Delegate, shared the importance of establishing a quorum to begin official meetings so that AI/AN challenges can be addressed with direct consultation with tribes. He stated that he serves as board member to the National Indian Health Board, on whose behalf he is presenting NIHB testimony for the 3rd Biannual Tribal Consultation Session. He mentioned that he appreciated CDC support, leadership, willingness to listen, work and response to important public health issues in Indian country. He noted that the tribe was there to strengthen their partnership with CDC, and request direct support in building a more equitable public health infrastructure through Indian country by addressing public health issues consistently identified by tribes as vital issues to reduce the health disparities and improve health status of AI/ANs.

The history was reiterated, 564 federally recognized tribal sovereign nations. With that ability to dialogue, collaborate, and consult directly with federal government regarding funding is very important. They recognize that tribal sovereignty can pose a unique challenge for CDC and other federal agencies, but these challenges can be readily

addressed through direct consultation of tribes. The NIHB serves as a centralized coordinated point, an important resource for tribes and federal partners to increase collaboration on communication activities; model, promising, and best practices; technical assistance and advocacy all increased the awareness of health disparities and public health issues in Indian country.

Through its leadership, CDC established TCAC in 2006 following the release of the Tribal Consultation Policy in 2005, which helped establish standards to guide CDC in working effectively with tribes and tribal organizations to ensure increased travel access to CDC programs and resources. The purpose of TCAC is to provide a complimentary venue where tribal leaders, CDC staff and other representatives can exchange information about public health issues, identify urgent public health needs of AI/ANs, and to discuss collaborative approaches to addressing these issues.

The tribe commends CDC for supporting TCAC and tribal consultation issues throughout Indian country. It is through that support that the tribes are here today. The TCAC supports strong government to government relationships between American Indian and Alaska Native Tribes and the federal government (CDC). The TCAC recognizes the role and responsibility that the CDC has for facilitating its grantees (states) to understand this relationship and assure that American Indian and Alaska Native Tribes benefits from resources awarded to states. States must be held accountable to ensure that CDC funds awarded to states are shared with American Indian and Alaska Native Tribes. CDC should make it a priority to develop policies, such as creating a States Guidance Document, which can both describe and enforce conditions requiring institutions to collaborate with a Tribe, Tribal organization, or Tribal entity. The TCAC requests increased accountability between states and Tribes to effectively address the health disparities faced by American Indian and Alaska Native people. The TCAC is confident that the CDC and ATSDR can aid in creating successful tribal-state relationships to improve health outcomes for American Indians and Alaska Natives.

Along these lines of increased direct funding and providing guidance to states, the TCAC requests the establishment of a technical subcommittee to evaluate how CDC program announcements and the grant application process can be modified to encourage more tribal applicants and to help ensure that tribal applicants have equal opportunities to compete successfully. CDC should understand the significant ability of tribes to determine what works and what is successful in Indian Country. To achieve this, Tribes should be involved from the beginning of the grant application process. The TCAC should be involved in the discussion and planning across CDC and its Centers to provide culturally appropriate planning for project officers in states with established AI/AN communities. Plans should be shared with the TCAC before implementing trainings. In addition, high priority should be given to: reforming grant requirements, such as the use tribal infrastructure for accounting processes; employing grant reviewers who are familiar with Tribes and trained in tribal health programs; developing standardized language for CDC program announcements that specifies tribal eligibility when appropriate and provides authoritative guidance on working with Tribes.

CDC's commitment to AI/ANs needs to be reflected in its annual budget. Mr. Freddie made a request to ensure allocation of resources to maximize the enhancement of public health capacities at the tribal level. It is the duty of CDC to provide programs to Indian country that will increase public health capacities, and prevent illness, injuries and

disease, while promoting health and wellness. As health services for AI/ANs are underfunded, budget requests should include provision for increase in allocation to AI/AN tribes to address public health prevention activities as a clear indication of CDC's commitment to meeting the healthcare needs of Indian country. Through other tribal consultation processes, tribes consistently identify tribal priorities. All of these priorities can, and should be addressed through CDC support and tribal action.

During the 2009 CDC Tribal Consultation, tribes identified the following: specific consideration and funding allocation, environmental health, epidemiology, public health, emergency preparedness, suicide prevention, and obesity prevention. A tribe request the establishment of a technical committee to evaluate CDC program announcement and grant application process can be modified to encourage more tribal applicants, and to help ensure the tribal applicants have adequate opportunity to compete successfully. To achieve this tribe should be involved during the beginning of the grant application process. The tribes should be involved in the discussion planning process. CDC and its centers, divisions, and agencies to provide culturally appropriate planning for projected project officers, and establish AI/AN community plans should be shared with tribes before implementing training. In addition, high priority should be given to reforming grant requirements such as the use of travel infrastructure, accounting, and processing. Develop standardized language for CDC program announcements that specific tribal eligibility when appropriate, and provide authoritative guidance when working with tribes. Expanding efforts to evaluate and ensure that funds awarded to state health departments appropriately benefit AI/AN populations in those states.

Raising the health status of AI/AN people should be the main goal of CDC as an agency, and with the new administration, it is imperative that CDC act upon commitment and obligation to fully implement procedures of CDC/ATSDR Tribal Consultation policies in the following ways: ensure that adequate staff and resources are available within the Office of the Director to support Tribal Consultation policy implementation; respond in a timely and effective manner to the recommendations made by TCAC and its advisory committee. The tribe requests that CDC leadership increase their interaction with tribes by increasing their level of participation with TCAC in tribally sponsored meetings, conferences, and consultation sessions in order to effectively address and respond to recommendations raised during these meetings. The tribe requests the opportunity to meet with the new CDC Director and ATSDR Administrator, Dr. Frieden, and other new CDC senior leadership in order for formerly establish these collaborative relationships in raising the health status of AI/AN people.

CDC should reaffirm its commitment to establishing a government-to-government relationship with tribal governments by committing funding to assist in the development of tribal and public health infrastructure. To achieve this, TCAC requests direct funding to tribes and increased funding allocations to American Indians and Alaska Natives. Allocation of CDC funds to states to address public health issues and health disparities does not assure that funds will actually get to Tribes or benefit American Indians and Alaska Natives. Many states do not have effective working relationships with the federally-recognized Tribes located with their state and do not understand the government to government relation based on tribal sovereignty. Tribes are not subservient to states: Tribes are sovereign nations. However, receiving funds that are passed through states is often difficult and sometimes impossible. In such instances where CDC funds states, states need to be held more accountable to fully engage tribes in all aspects of planning, implementing, and evaluating public health activities resulting

from the use of these resources. The CDC needs to hold states accountable for cooperating with requirements regarding the sharing and distribution of resources with the Tribes. The requirements for states should be strengthened: if a state receives money from CDC based on population numbers that include Indian Tribes, then the states must be accountable and ensure that tribes benefit from the funding that has been allocated to these ends. Activities and collaborations for the benefit of tribes need to be strategic to gain the greatest impact.

The TCAC recognizes the willingness of CDC to examine how federal resources are distributed and therefore requests that CDC leadership consistently assess whether Tribes are able to access critical health and human service program funding. The TCAC strongly objects to sending healthcare and public health monies outside the country without helping the United States Tribes, communities, and people first. One clear outcome of improved collaboration with the CDC is increased direct funding for tribes and urban centers. In this way, the new administration and CDC can meet its obligation to eliminate the health disparities within the US by directing Centers across CDC to set aside funding for Tribes. Mr. Freddie thanked the committee for their time.

- Tribal Leader Ching King, Ft. Belknap Indian Community, thanked the group for their time and participation. He reiterated the need to address specific health disparities such as obesity. He noted that AI/AN children should be put in their natural settings to overcome obesity instead of giving them Ritalin. He raised the issue regarding the use of prescription medicines such as Ritalin, by AI/AN youth. He asked why pharmaceutical companies test medications on AI/AN people, more specifically youth and Veterans. He also reemphasized the need to fund issues such as HIV/AIDS, Suicide Prevention, Environmental Health and Response, Behavioral Health, Nutrition and Physical Activity, and Diabetes Prevention and Control.
- Tribal Leader Sally Smith, Chairman, Bristol Bay Area Health Corporation (BBAHC), thanked the group for their patience. She mentioned CDC and the Arctic Investigations Program was a great resource for tribes in Alaska. She thanked ambassadors like Dr. Alan Parkinson, and Dr. Tom Hennessey for their great work with Alaska Native health issues. She thanked the group for coming and allowing them the ability to share. We are truly a partnership.
- Tribal Leader Cynthia Manuel, Councilwoman, Tohono O'odham Nation, stated that in order to improve communication and build stronger partnerships with the tribes, EPA established a National Tribal Operations Committee (NTOC). NTOC is comprised of 19 Tribal leaders (Tribal Caucus) and EPA's Senior Leadership Team, including the Administrator, the Deputy Administrator and the Agency's Assistant Administrators and Regional Administrators. She mentioned that NTOC meets on a regular basis to discuss implementation of the environmental protection programs for which EPA and the tribes share responsibility as co-regulators. She stressed that all tribes were encouraged to communicate with the members of NTOC. She participates on regular bases, and urged the group to visit their website for more information.

Wrap-Up, Summarization and Next Steps

Angel Dotoman, President/CEO Alaska native Health Board
Kathy Hughes, Vice Chairwoman, Oneida Business Committee, Bemidji Area, TCAC Co-Chair

Ms. Dotoman thanked the TCAC and CDC staff for coming to Alaska to learn, and hear the stories from their tribal leaders regarding issues that were currently affecting Alaska. She noted from the discussion, three major focus areas were covered during the morning's session, the first being Injury Prevention and Control. During this section, presenters discussed major issues such as Suicide Prevention, as well as funding for domestic violence, and making programs more culturally sensitive throughout CDC. In addition, the group discussed the importance of taking available grant funding and making it long term, as well as the importance of holding states accountable for pass through funding.

Ms. Dotoman noted the second area of focus was Chronic Disease Prevention and Control. The major theme throughout this section was ensuring that a true partnership remained between CDC and other tribal entities. As Ms. Smith mentioned, always asking the question "is this good for AI/AN people". Ms. Dotoman noted the informative presentations regarding Dental Health Aid Therapist Program, Camp COHO, cardiovascular disease, metabolic syndrome, diabetes, cancer, and other data driven presentations. She indicated that the Alaska Epi Center works very hard to ensure that they have data that is usable and true to what is taking place in the state.

The final area of focus from the morning session was Maternal and Child Health. She recognized the data driven presentations regarding STDs and sexual health among Alaska Natives. Overall, she noted good discussion from many people that were able to speak from their hearts concerning the major issues affecting the region.

Ms. Hughes communicated that there were three focus areas for the afternoon session as well, H1N1 Preparedness being the first. Comments from the Tohono O'odham Nation regarding border issues related to H1N1, and their request for CDC to take the lead in developing partnerships to assist tribes with planning. In addition, Mr. Finkbonner stressed the importance of learning from past H1N1 experiences, and the need to get accurate information out to the public.

The second focus area dealt with Health Reform, ARRA, and CDC Budget Priorities. The theme for this focus area centered around the unique opportunity that Indian country has to address health reform. Additionally, ARRA requests CDC to provide training and technical assistance needed within Indian country. In terms of Budget Priorities, many requests were made throughout the day for CDC leadership to consistently assess whether Tribes are able to access critical health and human service program funding.

Ms. Hughes noted the Tobacco-Related Health Issues and Building Health Communities centered around requests for culturally sensitive information to be provided to make the distinction, particularly for the youth, between commercial use of tobacco versus traditional use. Ms. Garbani noted that there were programs in the state of California that provided training and technical assistance that needed additional funding.

Ms. Hughes noted that participants would receive a written report of the meeting minutes.

Next Steps***Dr. Stephanie Bailey, Chief, Office of Public Health Practice******Dr. Kathleen Toomey, Director, Coordinating Center for Health Promotion***

Dr. Bailey thanked everyone for their valued participation. She stressed that CDC was committed to health, impact, scaling, prevention, and promotion of health. She reaffirmed CDC's goals to facilitate data access, provide technical expertise, improve communication, and become true partners with Indian country.

Dr. Bailey noted that while dollars were not unlimited, CDC would explore more ways to effectively utilize the dollars they possess. She stated that translational effectiveness was a new area of emphasis for CDC, and involving communities in the translation was extremely important; ensuring that all information and expertise is translated effectively into practice. She noted barriers such as research, competencies, workforce, and infrastructure could be combated with translational effectiveness.

In closing, Dr. Bailey asked "do you know where all of the tools are". She indicated that CDC could do a better job of developing, and centralizing tools. She reemphasized comments concerning peer review panels, Epi Aids, program guidance that may not be translatable, training for research, the CDC website, increasing CDC funding cycles, and decreasing the burden of CDC administrative overhead such as carryover, and noted they were all issues that she heard and would begin to address. She expressed that she was blessed to be able to hear the testimonies from tribal leaders, and looked forward to being a part of the solution.

Dr. Toomey thanked everyone for allowing her to participate in her first Tribal Consultation Session. She mentioned that she appreciated the candor of tribal testimony regarding issues such as concerns with fluoridation, NAPHSIS, and cultural sensitivity, all of which was extremely helpful for CDC to take notice of. She commented that their testimony represents a trust between all parties, which was important as they move forward.

Dr. Toomey recognized several key issues that she plans to address which include how important prevention is to AI/AN communities, and CDC's need to work in the continuum for prevention through clinical services and treatment, as well as assisting with the facilitation of that continuum; cultural sensitivity around all issues to allow flexibility in how CDC writes grants, or think about addressing intervention; data and its importance in health planning and being able to document issues and interventions; CDC's health information should be aggressively addressing issues such as racial misclassification for AI/ANs, strengthening the capacity of Epi Centers, linking data sets, enhancing youth risk behavior surveys. Finally, the clear message Dr. Toomey recognized was that AI/AN health must be viewed as a priority for CDC. She noted that this would not only manifest in additional dollars, but change the way CDC does business.

She mentioned that she appreciate everyone's input, and thanked them for allowing her to participate.

Ms. Hughes thanked everyone for their participation, and noted that anyone wanting to submit written testimony could do so within three weeks. Cynthia Manuel closed the meeting out in prayer.

The meeting adjourned at 6:35pm.

Participant Roster

TCAC Representatives (12)

Evelyn Acothley, Navajo Nation, Health and Social Services
Chester Antone, Tohono O'Odham Legislative Councilman
James Crouch, CRIHB, Executive Director
Joe Finkbonner NPAIHB, Executive Director
Jerry Freddie, Navajo Nation, Council Delegate
Kathy Hughes, Oneida Business Committee, Vice-Chairwoman
Byron Jasper, United Southern and Eastern Tribes (USET)
Jefferson Keel, Chickasaw Nation, Lt. Governor
Tracy "Ching" King, Ft. Belknap Indian Community
Alicia Reft, Karluk Ira Tribal Council
Governor Leon T. Roybal, Pueblo of San Ildefonso
Derek Valdo, NCAI Southwest Area Vice President, Pueblo of Acoma

Tribal Participants: (52)

Roy Agloinga, Norton Sound Health Corporation
Crystal Batt, ANHB
Lincoln Bean, ANHB, Vice-Chairman
Jim Berner, ANTHC
Stacy Bohlen, NIHB
Phllis Boskofsky, Maniilaq Association
Jennifer Charvet, Alaska Brain Injury Network
Robert J. Clark, BBAITE
Michael Covone, ANTHC
Elaine Dado, NPAIHB
C.N. David, MSTC
Christine Decourtney, ANTHC
Shawn Dick, APIA
Angel Dotomain, ANHB, President/CEO
Gary Ferguson, ANTHC
Aileen Fitzgerald, Kana
B. Francis, ANTHC
Corrine Garbani, Pechanga Band
Tim Gilbert, ANTHC
Cheri Hample, Chugachmiut
Sara Jackinsky, Ninirchik
L. Jackson, CRNA
Pat Jackson, ANTHC
CC Johnson, KIC
Janet Johnston, ANTHC
Wilson Justin, MSTC
Deborah Klaus, Navajo Division of Health
Nancy Knapp, SEARHC
Bill Kristovich, YKHC
Tom Lefebvre, ANTHC
Jessica Leston, ANTHC

Martha Little Light, Crow Nation
Ted Mala, SCF
Cynthia Manuel, Tohono O'Odham Legislative Council
William Martin, CCTHITC
Buffy McKay, ANHB
Philbert Morgan, Navajo – EPA
Matt Murphy, CDC, NCEH
Isabel Nashookpuk, ASNA
Jaylene Nyren, Kenaitze
M. Ramesh, ANTHC
Melissa Robbins, APIA
Carlos Romero, student observer
Geoffrey Ruth, NCUIH
Agnes Rychnovsky, BBAHC
Jim Seguna, S/Central
Desiree Simeon, ANTHC
H. Sally Smith, BBAHC
Wm. F. Smith, Valdez Native Tribe
Audrey Solimon, NIHB, Program Manager
Ileen Sylvester, SCF
June Walunga, NSHC

Federal Participants: (23)

Stacey Ecoffey, HHS
Kathleen Toomey, CDC, Coordinating Center for Health Promotion, Director
Stephanie Bailey, MD, CDC, Office of Public Health Practice, Chief
Rob Curlee, CDC, Financial Management Office, Deputy Director - Budget
Capt. Pelagie (Mike) Snesrud, CDC, Senior Tribal Liaison for Policy and Evaluation
Capt. Ralph Bryan, CDC, Senior Tribal Liaison for Science and Public Health
Annabelle Allison, CDC, ATSDR, Environmental Health Scientist, Tribal Affairs Liaison
William Ryan, CDC, PGO
Richard Kauffman, CDC, ATSDR, Senior Regional Representative, Region X
Lauren Lewis, MD, CDC, NCEH/DEHHE/HSB, Branch Chief
Tom Hennessy, MD, CDC, Arctic Investigations Program, Director
William Kohn, DDS, CDC, Division of Oral Health, Associate Director for Science
Ryan Hill, CDC, NIOSH, Occ/Env Safety and Health Specialist
Holly Billie, CDC, CCHEHIP, NCIPC
Nick Burton, CDC, NCCDPHP, Public Health Analyst
Jay Butler, CDC, NCPDCID/DEISS, Program Director
Jennifer Charvet, Alaska Brain Injury Network
Pyone Cho, MD, CDC, NCCDPHP/DDT, Epidemiologist
Melanie Taylor, MD, CDC, NCHHSTP, Medical Officer
Timothy Thomas, MD, CDC, NCHHSTP, Medical Officer
Joe Sarcone, CDC, HJAAB/DRO, Regional Representative
Paul Melstrom, CDC, NCEH
Elizabeth Hensley, State of Alaska