



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

**Tribal Consultation Advisory Committee (TCAC) Meeting Minutes  
August 11<sup>th</sup> & 13<sup>th</sup>, 2009**



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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 11<sup>th</sup> and 13<sup>th</sup>, 2009**

**August 11, 2009**

**Call to Order, Opening Prayer, Welcoming Remarks, Introductions**

**Jefferson Keel, Lt. Governor, Chickasaw Nation  
Chair, Tribal Consultation Advisory Committee (TCAC)**

**Tim Gilbert, Director of Community Health Services  
Alaska Native Tribal Health Consortium**

**Captain Pelagie (Mike) Snesrud  
Senior Tribal Liaison for Policy and Evaluation  
Centers for Disease Control and Prevention (CDC)**

On Tuesday, August 11, 2009, the meeting of the Tribal Consultation Advisory Committee (TCAC) was called to order at 8:17AM by Jefferson Keel, Lt. Governor of the Chickasaw Nation and TCAC Chair. Following an opening prayer from Tim Gilbert, Director of Community Health Services, Alaska Native Tribal Health Consortium, Mr. Keel welcomed the group to the meeting and thanked them for their participation. He extended a special thanks to the Alaska Planning Committee for their hard work in arranging the meeting. Attendees from the meeting then introduced themselves. A participant roster can be found in Appendix A.

CAPT Mike Snesrud, CDC Senior Tribal Liaison for Policy and Evaluation welcomed the group and thanked them for their time and participation. She stated that the TCAC continues to be very important to CDC because of the great need for CDC to be informed by tribal leadership from across Indian country about priority public health issues. CAPT Snesrud stated that the trust relationship between CDC and AI/AN Tribes is evolving as we increase our understanding and knowledge of one another. The TCAC has played and will continue to play a significant role in the strengthening of this relationship with the ongoing dialogue and guidance provided by the TCAC membership. CDC remains committed to increasing access to CDC programs and resources and increasing partnerships with tribes to achieve the greatest impact on health disparities among AI/AN populations. She noted that while it was important to hear from individual tribal leaders, CDC also needs to hear collectively from the TCAC about the highest priorities for Indian country. It is imperative that TCAC determine the best process to prioritize its recommendations to CDC. As we look ahead to future TCAC Meetings, she asked for assistance from TCAC in determining a frequency of conference calls that will be respectful of busy schedules and assure a greater level of membership participation (quality vs quantity).

*Lt. Governor Keel closed the meeting to the public at 8:32 to go into Executive Session.*

## Executive Session

**Jefferson Keel, Lt. Governor, Chickasaw Nation  
Co-Chair, Tribal Consultation Advisory Committee (TCAC)**

### **Review and Approval of February 2009 Meeting Minutes**

Lt. Governor Keel asked the committee to review and discuss applicable changes to the February 2009 Meeting Minutes.

Kathy Hughes, Vice-Chairwoman, Oneida Business Committee, Bemidji Area, added that the participant list should reflect both the participant's name and area represented.

#### **Motion**

Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board (NPAIHB), made a motion to approve the February 2009 Meeting Minutes with changes. Vice Chairwoman Kathy Hughes, Oneida Business Committee seconded the motion. The motion passed unanimously with no abstentions.

### **Review and Approval of June and other Conference Call Meeting Minutes**

Lt. Governor Keel asked the committee to review and discuss applicable changes to the June and other Conference Call Meeting Minutes. Mr. Finkbonner noted on Page 2 of the July 17, 2009 Conference Call Minutes; the word planned was misspelled in the second sentence.

#### **Motion**

Vice Chairwoman Kathy Hughes, Oneida Business Committee made a motion to approve the March 20 and June 11 Conference Call Minutes. Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board (NPAIHB), seconded the motion. The motion passed unanimously with no abstentions.

Lt. Governor asked the members of the TCAC to address additional corrections to the remaining Meeting Minutes at the end of the meeting.

### **TCAC Co-Chair Elections**

#### **Motion**

Lt. Governor Keel, Chickasaw Nation and TCAC Chair, made a nomination to elect Chester Antone, Tohono O'odham Legislative Councilman, as a TCAC Co-Chair. Derek Valdo, National Congress on American Indians (NCAI) Southwest Area Vice President, Pueblo of Acoma, nominated Kathy Hughes, Vice Chairwoman, Oneida Business Committee, as a TCAC Co-Chair. Mr. Jerry Freddie, Council Delegate, Navajo Nation, moved that nominations cease and Mr. Antone and Ms. Hughes be elected by acclamation. The motions passed unanimously with no abstentions.

CAPT Mike Snesrud, CDC Senior Tribal Liaison for Policy and Evaluation, noted that even though the existing TCAC Charter was revised, voted on, and approved during the November 2008 TCAC Meeting, it was the responsibility of the Office of Intergovernmental Affairs to ensure that the charter was consistent with other advisory committee charters. CAPT Snesrud stated that the TCAC had been fortunate enough to receive counsel from Stacey Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental Affairs (IGA), Department of Health and Human Services (HHS), who would update the committee and consult with TCAC Co-Chairs concerning the charter revision.

Ms. Ecoffey stated that Tribal Affairs was an integral component of the Office of Intergovernmental Affairs (IGA). Tribal Affairs conducts on-going outreach to tribes and tribal organizations around the country. IGA Tribal Affairs advises IGA leadership and HHS Senior Staff on how to best address the unique needs of their constituency. Ms. Ecoffey acknowledged that their new director was passionate about expanding their current advisory committees, and ultimately establishing a Secretary's Advisory Committee, and has thus begun a rigorous review of their current advisory committees. During this review, IGA Tribal Affairs discovered that several advisory committees were in jeopardy of losing their (Federal Advisory Committee Act FACA) exemption. Currently, all of the committees fall under FACA, where there is a specific portion that gives elected state, local, and tribal officials an exemption for these committees. Ms. Ecoffey noted that right now, each one their committees triggers FACA.

Ms. Ecoffey revealed that her office was in the process of establishing official documentation with suggestions regarding how the FACA exemption issues could be addressed, and to also identify core charter principles such as membership, function, selection of term, et cetera, to establish consistency. IGA's goal is to also be more inclusive of tribes that are not national representatives, and to have a more direct relationship with tribes.

Ms. Ecoffey noted another issue that has triggered FACA was the selection of the members on the advisory committees. She stressed the importance of having the elected tribal official, in their capacity, officially designate their delegate in writing.

### **Discussion Points**

- Ms. Hughes asked if it would help if the national committees had something in their charter and bylaws that explained their representation of Indian country, since most people on the national committees are placed there by elected officials. That is, if there were something specifically in the bylaws that referenced that chain of events, would this help?
- Ms. Ecoffey replied that the problem is that the national organizations, in their own right, are not governments. The exemption is for local, state, and tribal governments. She stated that the Washington-based groups could be designees per FACA. Currently, there are only three Washington-based groups: the National Indian Health Board, the National Congress of American Indians, and Tribal Self-Governance.
- Lt. Governor Keel commented that during the first meeting the TCAC convened in Atlanta when the charter was developed (Nov. 2006), the committee used the Tribal Technical Advisory Group (TTAG) charter as a model to develop this language. Regarding TCAC appointments, in other advisory committees that deal with health, historically the IHS Area Director has been the appointing authority, which he felt was an error since IHS has no authority in relation to CDC. He commented that if there is an appointing authority, it should be the director of the CDC.

- Dr. Bryan replied that the IHS Area Directors do not appoint TCAC members; the selection and appointing comes from the area health boards.
- To clarify, CAPT Snesrud shared an example, that initially, the TCAC had difficulty obtaining participation from the Bemidji area because they do not have area health boards. She further stated that she independently sought assistance from Ms. Hughes, and others in the Bemidji area who agreed that the IHS Area Director could assist with the solicitation but not the selection/appointment of a tribal leader to TCAC. CDC looked to MAST, an area tribal consortium to select and nominate a primary and alternate tribal leader, which was in compliance with the existing TCAC charter.
- Lt. Governor Keel stressed that it needed to be clarified that area health boards can assist in the process, but the appointing authority of tribal leaders to the TCAC should come from the Director of CDC. If the IGA is going to establish rules to standardize charters within HHS, then there needs to be an HHS approved model.
- Ms. Hughes stated that she was a member of several committees, and that there was no consistency in the standards of appointment.
- Ms. Ecoffey agreed that there needs to be some consistency with the core principals, which will make things easier for the departments and the tribes to understand. She noted that if a new administration were to come in that does not understand tribes, they would at least have a basis for how the tribal advisory committees work, and how they are selected. She stressed the importance of compromising so that tribal advisory committees could come together, but still remain FACA exempt. Ms. Ecoffey stated that the IGA Tribal Affairs Director wanted to meet with the advisory committee co-chairs during the NIHB Annual Meeting in Washington, DC or NCAI Annual Meeting to discuss these issues.
- Dr. Bryan asked whether the TCAC should wait for IGA to provide specific guidance before they could move forward with modifications to the charter, or if could they proceed with the specific guidance that was given.
- Ms. Ecoffey replied that she would prefer the TCAC waited until IGA provided an official document to proceed. She noted that some of the core principles that IGA would be examining were membership, selection of members, terms, and defining the national representatives. She added that none of ACF's national organizations are Washington-based, which is a disservice to Indian country because the National Indian Child Welfare Association (NICWA) is based in Portland. It was not clear how they could adequately represent the views of the tribes when they could not have a seat as a national representative.
- Dr. Bryan asked when the TCAC could expect to see the guidance document so that they could project future meetings.
- Ms. Ecoffey responded that the TCAC should be able to begin discussion regarding the charter during its next meeting.
- To clarify, Mr. Bryan asked if the TCAC should postpone the charter revision process until they receive the guidance, and if so, whether this would delay revisions to the charter that

need to be made that do not relate to the FACA issue, which would impact the TCAC's ability to conduct business between currently and in the next year.

- Ms. Ecoffey stressed that the TCAC could continue to do business as usual. She noted that IGA just wanted to give all of their advisory committees advance notice of the forthcoming guidance.
- CAPT Snesrud added as the TCAC first began to develop its charter, CDC looked to the area tribal health boards to become the appointing entity to allow for the uniqueness's and differences that do exist from one area to another. During the initial appointment process, an issue that arose from some of the health boards was how one tribal leader could represent all of the tribes in a given area. CAPT Snesrud noted that USET still has not appointed a tribal leader to the TCAC because their board of directors determined and communicated to CDC that USET would send only USET staff due to their policy that no tribal leader could speak on behalf of other tribes from that area. She also noted that during the Feb. 2009 TCAC Meeting in Albuquerque, the All Indian Pueblo Council (AIPC) had asked to meet with TCAC leadership and the CDC. AIPC voiced the concern as to how the Albuquerque Area Indian Health Board (AAIHB) which includes membership of only 7 tribes in the Area could represent the issues affecting all the tribes in the Albuquerque Area. CAPT Snesrud stated that CDC's goal is not to be exclusive or prioritize any tribe but rather to create a venue for multiple tribes and tribal leadership that want to dialogue with CDC to be able to do so. Before the establishment of the TCAC, there was no ongoing dialogue or no process in place for tribal leaders to dialogue with CDC. Through the agency's Consultation Policy and the TCAC there are now several venues articulated and available. CDC in consultation with the tribes determined the area health boards or a area tribal consortia would identify a tribal leader from each area. CDC invites all tribal leaders to contact the Senior Tribal Liaisons, the NCEH/ATSDR Tribal Liaison, the TCAC leadership or the TCAC member from their area, and/or a Subject Mater Expert (SME) they are already working with on CDC grant or cooperative agreement to get assistance and voice a concern or recommendation. TCAC meetings are open meetings unless determined otherwise by TCAC leadership.
- Mr. Gilbert commented that he appreciated the information that Ms. Ecoffey presented. He stressed the importance of doing whatever it would take to legitimize the TCAC. He noted that it would be difficult to be too prescriptive about each area's appointment mechanisms. He also pointed out that in Alaska, IHS is not involved. The tribes conduct the appointments. He also thought that as the guidance document is being prepared, that the IGA consider the effect of adding more member seats to the TCAC.
- Mr. Valdo added that staff of area health boards could acquire letters designating tribal representatives as a suggestion regarding how the appointment issue could be handled. He is currently the co-chair of the SAMSHA TTAG, and they are hearing the same requests that they need staff on the committees since they are the experts that are employed by the tribes. SAMSHA has since created subcommittees through which they can bring staff to help give the tribal leaders the information to present to their federal officials. He stressed that consultation was government-to-government, and that if they start to dilute the process with staff participation, it loses the value of a tribal leader. There are 24 tribes in New Mexico, and the AAIHB only represents 5 (includes 3 Chapters of the Navajo Nation) of those 24 Nations. AAIHB has become very resistant to allowing more Pueblo input, so now there is a Pueblo health committee that competes with AAIHB. This is a trend that will

continue as the TCAC becomes more advanced, builds more infrastructure, and develops more capacity. More interest groups will begin to arise. SAMSHA's charter is almost identical to TCAC's, including the section dealing with unlimited terms. Mr. Valdo requested that the committee determine how they can position the TCAC to be efficient and effective voices for Indian country.

- Ms. Ecoffey added that the law states that tribes can designate, but they must show proper documentation for each designee. She also stressed the importance of understanding that the TCAC and the other IGA committees are not consultation committees, but rather advise giving committees that are in place to advise the agencies and departments with respect to how tribes view certain issues.

### **Upcoming TCAC Meetings and Biannual Consultation Sessions**

CAPT Snesrud solicited the committee for dates of next TCAC meeting and Biannual Consultation Session. She suggested either late January or early March. TCAC Co-chair, Chester Antone asked the committee if they would agree to forward suggested dates to build consensus. The committee unanimously agreed with no abstentions.

### **Monthly TCAC Informational Calls and Quarterly TCAC Calls**

CAPT Snesrud noted that several committee members expressed frustration regarding the lack of participation by the TCAC membership on conference calls, and requested that the committee needed determine a frequency of the calls. In addition, she stated that a suggestion had been made on a previous TCAC Call that TCAC business call be held every other month with a TCAC Informational Calls on alternate months. The purpose of Informational Calls would be for tribal leaders and CDC to share and update each other regarding new programs, initiatives, et cetera.

#### **Motion**

Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board (NPAIHB), made a motion to close the Executive Session. Vice Chairwoman Kathy Hughes, Oneida Business Committee, seconded the motion. The motion passed unanimously.

The session was re-opened back to the public at 9:51AM.

## **Administrative Matters**

### **TCAC Response to Division of Immunization Services Division (ISD) about inclusion of new vaccines in the Vaccines for Children Program (VFC)**

CAPT Snesrud reminded the group that Dr. Lance Rodewald, Director of the ISD was still waiting on a written response from the TCAC regarding guidance concerning a 90-day deadline for the implementation of new vaccines into a state's VFC program.

#### **Discussion Points**

- Dr. Bryan stated that the committee has been remiss in the sluggishness of their response to the VFC regarding their presentation during the February TCAC meeting. He noted that if

the TCAC wanted their CDC colleagues to travel and solicit input, the committee needed to respond in a timely manner when written feedback was required.

- Mr. Crouch apologized for the delay, and asked what the VFC Program specifically needed from the committee.
- CAPT Snesrud explained that over the past two years, there have been more immunizations that have been recommended. Some states respond in a timely manner and make those immunizations available, and other states do not. Because AI / AN children are eligible, and are prime recipients of those immunizations that are offered through the VFC Program, Dr. Rodewald solicited the TCAC to make a recommendation to CDC.
- Mr. Crouch stressed the importance of ensuring that states not delay the implementation of new vaccines into the VFC program, which causes Indian country to be negatively impacted. He suggested that since potential language had already been drafted, the TCAC Co-chairs should finalize the letter and send out as soon as possible.
- Dr. Stephanie Bailey suggested that the TCAC try utilizing Cospire, online software that CDC currently uses, which is uniquely designed around people to foster a healthy knowledge sharing community. She noted that one of the largest problems for businesses and organizations today is the inability to manage knowledge and time effectively. Having easy access to the right information when you need it, as well as an infrastructure that fosters creation and sharing of new knowledge, are essential assets for any collaborative effort.

*With no further commentary, the session was adjourned at 10:06 to conduct the tour of the Alaska Native Medical Center Campus.*

### Site Visit to Alaska Native Medical Center Campus

The group arrived at the Alaska Native Medical Center (ANMC) at 11:02 AM for a tour of the campus. The tour consisted of ANMC Primary Care Center, the Arctic Investigations Program Facility, and the ANMC Administrative Offices.

#### **Arctic Investigations Program (AIP)**

Dr. Thomas Hennessey, Director of the CDC Arctic Investigations Program (AIP) in Anchorage, welcomed the group and gave a brief overview of the AIP. He indicated that AIP has over 50 years of experience in improving Arctic health. The AIP mission is prevention of infectious diseases in people of the Arctic and Sub-Arctic, with special emphasis on diseases of high incidence and concern among Alaska Natives and American Indians. The staff at AIP provides support for infectious disease prevention and control research studies through applied epidemiology, laboratory, computer, and statistical sciences.

Dr. Hennessey noted the priority areas of focus for AIP include disease surveillance, emerging infectious diseases, health disparities, preparedness and response, and leadership and circumpolar health. Their priority infections include vaccine preventable infections; infections

that lead to chronic disease, such as helicobacter pylori infections which causes stomach ulcers and stomach cancer; and emerging infections such as Avian Influenza.

Surveillance AIP, with the help of hospitals and clinics across Alaska, operates a surveillance system to monitor the occurrence of illnesses caused by a select group of bacteria. This monitoring is done to be able to document rates of diseases caused by these organisms, to look for trends over time and across regions of the state, to provide additional laboratory testing and identification of the organisms and their specific characteristics, to provide current and historical data to aid in making and interpreting decisions that may affect public health, and to provide a basis for further study of the diseases and their occurrence in Alaska.

Several of AIP's partners include the Alaska Native Tribal Health Consortium (ANTHC), the State of Alaska Division of Health, the municipality of Anchorage Health Department, the University of Alaska, ANMC, and the Yukon-Kuskokwim Health Corporation. He also noted that AIP pulls a lot of CDC expertise to Alaska to help address issues affecting the area.

Dr. Hennessy said that he views the AIP as an established, successful research station with an epidemiologic and laboratory integration that focuses on regional health issues. He noted that AIP provides a strong platform for partnerships that combine CDC subject matter expertise with local knowledge, contacts, and co-validity of operations. In addition, the AIP are leaders in applying research activities to domestic and international projects

The group took a brief tour of the AIP facility, which included the Alaska Area Specimen Bank, which houses specimens collected during research public health investigations, chemical tests since the early 1960s, and AIP laboratories and offices.

### **Alaska Native Medical Center Primary Care Center**

The Alaska Native Medical Center (ANMC) is part of a network of health care providers located in small village clinics, health centers, and regional hospitals. ANMC provides comprehensive medical services to Alaska Native and American Indian people living within the state. The Center includes a 150-bed hospital, a full-range of medical specialties, primary care services, labs, and covered parking.

The hospital also works in close partnership with rural health facilities statewide to support a broad range of health care and related services. As a statewide referral center, ANMC provides the Quyana House for patients and their escorts from surrounding areas, a 56-room, 108-bed facility. The Quyana House provides housing, travel services, and Medicaid authorizations. Together the Alaska Native Tribal Health Consortium and Southcentral Foundation jointly own and manage ANMC. These parent organizations have established a Joint Operating Board to ensure unified operation of health services provided by the Medical Center.

ANMC serves four basic functions which include primary care provider for Native residents of Anchorage and the Matanuska and Susitna valleys; clinical services support for primary care providers in all Anchorage Service Unit communities; acute care community hospital services for Native residents of Anchorage Service Unite area communities; and statewide tertiary and specialty hospital and clinics for Alaska Native or American Indian.

The full-service emergency department is certified as a Level II Trauma Center by the American College of Surgeons. It is the only emergency department in the state to achieve this status.

ANMC is the first healthcare organization in Alaska and the first tribally owned and managed facility to receive the prestigious Magnet designation from the American Nursing Credentialing Center.

In addition to the specialized team of physicians, the hospital's medical staff consists of ANMC Case Managers who serve as advocates for the patient and family; a twenty-four hour nursing care staff comprised of a team of professional registered nurses, licensed practical nurses, and nurse assistants; pharmacists and pharmacy technicians who work with nurses, doctors, and others caring for the patients; social workers who serve each patient care area to help patients and family members deal with the social, emotional, and resource issues related to illness, disability, and / or hospitalization. They can help families deal with and cope with the effects of long-term illness, disability, and rehabilitation. They also serve as part of the discharge planning team. Volunteers and auxiliary members contribute many hours of service to the hospital. They may read to children, hold babies, visit patients, and serve as interpreters.

ANMC was designed to ensure warm, welcoming gathering places that reflect the Alaska Native sense of community. The lobby is octagonal in shape and reminiscent of an Athabascan kashim, or traditional community hall. Major artworks by well known Alaska Native artists are displayed prominently throughout the facility. This helps the healing process and creates a sense of pride in Alaska Native cultures. The landscape design reflects Alaska's geographic panorama, incorporating plants used in traditional medicinal practices of Alaska Natives and American Indians.

The group took a brief tour of the of the hospital, which included ANMC's Internal Medicine Clinics, Emergency Room and Urgent Care Center, Pediatric and Women's Care Unit, and several Specialty Clinics. In addition, the group was afforded the opportunity to tour the new wing of ANMC, scheduled to open next year, which focuses on a more intimate, yet comprehensive family medicine experience.

### **ANTHC Alaska Federal Health Care Access Network (AFHCAN) Telemedicine Demonstration**

The group arrived at the ANMC Administrative Offices at 4:37 PM for a Telemedicine demonstration. Telehealth is one example of the way tribal health organizations work together to provide quality care to their families. The role of the Alaska Federal Health Care Access Network (AFHCAN) is to support and promote access to care through statewide telehealth activities. Telehealth is the use of medical equipment, computers, and satellites to connect patients and medical providers across great distances. Through telehealth, patients are able to remain in their home communities, yet be seen by physicians in regional or urban centers.

The AFHCAN Cart is a mobile workstation with integrated biomedical peripherals, wireless network capability, and power management hardware that allows health care professionals to capture patient information using electronic forms and integrated biomedical peripherals, capture information from external imaging devices such as microscopes, ultrasound and surgical scopes, and forward the information to another professional or group of professionals at a distant location for review and consultation.

The cart is small enough to fit through a door, has large rubber wheels to negotiate uneven floor surfaces, has a low center of gravity to minimize instability, and is designed to meet the ergonomic needs of a wide variety of users. It is designed for patient safety with low EMI and an isolated power system.

The earscan provides threshold screening audiometry plus fast and normal speed tympanometry. The tympanometer measures compliance of the ossicular chain, middle ear pressure, ear volume and acoustic reflex. The audiometer performs automatic air conduction threshold hearing tests in seven minutes. It has pure tones with standard headphones and smooth response button. In addition, there is a small dental camera with superior optics, auto focus, and excellent color reproduction. Dental professionals can rely on its high quality images for all remote dental examinations.

A 12 megapixel digital camera with high definition video is attached to the cart. When tested on skin and other clinical images, the camera demonstrates excellent image quality in terms of color and detail. The camera is just large enough to hold by the four corners and has easily accessible functions. The camera fits nicely into the Kodak docking station that provides battery charging and image transfer. The Cart also has a built in CPU, which allows ECGs to be easily created.

### **Thursday, August 13, 2009**

#### **Opening Prayer, Welcome, and Introductions**

#### **Chester Antone, Lt. Tohono O’Odham Legislative Councilman Co-Chair, Tribal Consultation Advisory Committee (TCAC)**

On Thursday, August 13, 2009, the meeting of the Tribal Consultation Advisory Committee (TCAC) reconvened at 8:46 AM with an opening prayer by Chester Antone, Tohono O’Odham Legislative Councilman and TCAC Co-Chair. He welcomed the group back and expressed his appreciation for everyone’s participation. Attendees from the meeting then introduced themselves. A participant roster can be found in Appendix A.

Mr. Antone asked for clarification regarding the deletion of the section pertaining to the CDC Director’s Inquiries and Areas of Interest from the agenda. Dr. Bailey responded that she would be able to give a detailed report at a later date regarding new CDC initiatives engaging health disparities since the information had not been finalized. Mr. Antone asked if there were additional concerns regarding the agenda as well as a motion to accept the agenda with changes.

#### **Motion**

Evelyn Acothley, Navajo Nation, Health and Social Services, made a motion to approve the agenda with changes. Alicia Reft, Karluk Ira Tribal Council, seconded the motion. The motion passed unanimously with no abstentions.

#### **TCAC Members Regional/National Updates**

#### **United South & Eastern Tribes (USET)**

**Byron Jasper  
Deputy Director, Public Health**

Mr. Jasper reported that the USET Board, which is comprised of 25 tribal leaders, has gone through a recent transition. Their Executive Director, Michael Cook, resigned and they currently have an interim director. USET will conduct its annual meeting at the Hard Rock Hotel and Casio in Hollywood, Florida, where they will celebrate the 40<sup>th</sup> Anniversary of USET. He noted that originally USET had four founding tribal groups: the Miki Suki Tribe, Florida Seminole, Mississippi Band of Choctaws, and the Easter Band of Cherokee Tribe.

Mr. Jasper informed the group that the USETs operate their area Diabetes Program, and have recently completed their Diabetes Audit Data Report, which is a statistical analysis of all of the diabetes audit data. In addition, he reported that the Mashpee Tribe of Connecticut recently joined USET. Mr. Jasper stressed that the tribes are working hard and are actively engaging in issues such as health care reform and the reauthorization of the Indian Healthcare Improvement Act.

### **Navajo Area**

#### **Jerry Freddie**

#### **Navajo Health and Social Services Committee, NIHB**

Mr. Freddie reported that through the NIHB-CDC Cooperative agreement, the NIGH has been able to utilize the funding to aid in the dissemination of pertinent public health information to the Tribes via the following communication methods:

1. The NIHB Washington Report: The NIHB continues to publish this newsletter on a bi-weekly basis on the current legislative issues occurring on Capitol Hill and the work the NIHB is doing on health care reform, and other important updates related to the Indian Health Care Improvement Act (IHCIA). The publication will soon move to a weekly publication.
2. 2009 NIHB Annual Consumer Conference Save-the-Date-Card: The NIHB created the save-the-date card to disseminate to Tribal Leaders, community members, Tribal health Board Directors, Tribal Epidemiology Center Directors, and Tribal health care providers and public health officials and inform each Tribal entity about the upcoming NIHB ACC.
3. "How the NIHB Works": A quick review guide / 1-page document about the NIHB organization and Board Members work on behalf of the 562 federally recognized tribes with and how the organization works with national, state, local, private foundations, Tribal advisory groups, Area Health Boards, and its role in advocating on behalf of the tribes for quality health care and the reduction of health disparities.
4. "How the IHCIA Addresses health Issues in Indian Country": A 2-page document that gives a quick review of the IHCIA reauthorization bill (H.R. 2708), stating the health issue, the current problem (statistics), and the IHCIA solution.
5. NIHB: Focusing on Tribal Public Health: A 1-page document that reviews the NIHB public health current activities and programs the NIHB is providing coordination, technical assistance to as well as those programs the NIHB is championing and supporting on behalf of the tribes.
6. "Restoring the Balance" Tribal Public Health Brochure: With the support of the CDC throughout the NIHB-CDC Cooperative Agreement, the NIHB created this brochure to help tribes understand the importance of public health in Indian country and offer examples of public health activities. The NIHB is currently in the process of carrying out a dissemination plan to introduce the brochure to Indian country.

7. NIHB Health Reporter: Published quarterly, the NIHB Health Reporter is a comprehensive review of activities and programs the NIHB is working on / participating in and provides updates and information on upcoming events.
8. 2009 TCAC Calendar: The yearly calendar put together by the NIHB for the TCAC membership with important dates of upcoming events, conferences, and advisory council meetings to allow for adequate and appropriate planning of events and to reduce meeting conflicts.
9. Sebelius / Duncan Letter Regarding H1N1 Flu Preparedness (June 11, 2009): Sent to educators and disseminated to tribes via national tribal organizations including the NIHB and local, state and federal agencies, as a pre-planning/informative letter to create awareness of the potential H1N1 flu outbreak for the fall 2009 season, specifically for children returning to school.
10. NIHB Review of their attendance at the H1N1 Influenza Preparedness Summit at the NIH: On June 11, 2009, an NIHB board member and staff member attended the H1N1 Flu Summit held at the NIH campus. This document provides an update on the information covered.
11. NIHB Health Alert RE: H1N1 Funding Deadlines: The NIHB released a Health Alert to alert the tribes of the upcoming deadline for the H1N1 preparedness plan consultation with states and local governments. The Health Alert encouraged tribes to contact their local and / or state health departments to ensure inclusion in the planning process and funding.
12. Preparing Tribal Nations to Receive Strategic National Stockpile Assets: A publication of the CDC, the NIHB will aid in the distribution of this document to help the tribes prepare for the upcoming H1N1 vaccine distribution and immunization efforts.
13. FY2011 Tribal Budget Recommendations to the CDC & ATSDR: Strengthening Public Health Capacity for Stronger Tribal Communities: Official written testimony offered by Councilman Jerry Freddie at the April 2009 Department of Health and Human Services Tribal Budget Consultation Session in Washington, DC. The NIHB provides this testimony on its website as resource for tribes and to inform the tribes of the efforts of the NIHB on behalf of the tribes.
14. Letter of Invitation to Dr. Thomas Frieden to the 2009 NIHB Annual Consumer Conference: In order to provide a forum for the tribes to communicate directly with the CDC Director and Administrator of the ATSDR, the NIHB has invited Dr. Frieden to deliver a keynote address at the 2009 NIHB ACC.
15. Tribal Public Health Accreditation (TPHA): A 1-page document that gives a brief overview of what the TPHA is, what it does, and the progress made to date.

Mr. Freddie also reported that the NIBH was able to participate in and offer technical assistance to the FY2011 Tribal Budget Foundation Workgroup during late February 2009 in preparation of official written and verbal testimony to the Department of Health & Human Services during their budget consultation session held in Washington, DC in April 2009. In the final written testimony, the budget formulation workgroup, on behalf of the Tribes, identified the National Tribal health care priorities which target the most immediate health disparities among American Indians and Alaska Native people.

The top health priorities included:

1. Diabetes
2. Cancer
3. Behavioral Health / Alcohol / Substance Abuse / Mental Health
4. Cardiovascular Disease / Heart Disease / Stroke
5. Health Promotion / Disease Prevention

6. Injuries / Injury Prevention
7. Maternal and Child Health
8. Dental Health
9. Water and Sanitation
10. Respiratory / Pulmonary Issues

In addition, the NIHB recently received news that the National Association of County and City Health Officials (NACCHO) and the PHAB will be providing funding to the NIHB to aid in the beta-testing that will be occurring in two (2) tribal areas to assess the TPHA process and help with beta testing data collection, serving as a coordination center and provide technical assistance to the tribes.

Mr. Freddie noted that during September 14-17, 2009, NIHB will hold its 26<sup>th</sup> Annual Consumer Conference in Washington, DC at the Hyatt Regency Capitol Hill. The theme of the conference is "Indian Health in the Era of Healthcare Reform," and will feature a variety of Congressional speakers, tribal leaders, and community member speakers involved in grassroots public health activities in tribal communities; Centers for Medicaid Services speakers and presentations on best practices; and a variety of public health topics of importance in Indian country. In addition, the HICI project will be launching its official HICI Online Resource Guide that highlights the promising prevention practices that are currently underway throughout Indian country. Prevention topics such as suicide prevention, obesity prevention, addressing historical trauma, and promotion of health behaviors such as returning to traditional gardening as a form of healthy eating and engaging community members in physical activities by relating them to traditional / cultural activities are addressed. Information pertaining to what works, barriers encountered, and general project information will be presented in an online, web-based format.

Mr. Freddie also reported that the NIHB is currently in the process of the dissemination of the "Restoring the Balance" Tribal Public Health Brochure that was created with the help of funding from the NIHB-CDC Cooperative Agreement. The NIHB dissemination plan includes providing the brochure to Tribal Health Center Directors, Tribal Epidemiology Centers, Tribal Health Centers, and the IHS facilities and clinics within each of the 12 areas. This first wave of dissemination will allow the tribes to be introduced to the brochure and the NIHB is in the planning process of a second dissemination wave that will include a broader population that will include CDC divisions and agencies as well as the larger public health profession population. The NIHB also plans to disseminate the brochure during attendance at various conferences, both tribal and non-tribal.

### **National Congress of American Indians (NCAI)**

#### **Derek Valdo - Southwest Area Vice President, NCAI**

Mr. Valdo reported that NCAI continues to be very active in ensuring that tribal provisions are in most of the legislation back east, Insurance Reform being the most pressing issue. He mentioned that NCAI recently purchased an embassy, and the grand opening for the embassy will take place in Washington, DC on August 26, 2009. In addition, NCAI's Annual Meeting is scheduled to take place October 12-16, 2009 in Palm Springs, California.

### **Tucson Area**

**Chester Antone, Councilman  
Tohono O'odham Nation**

Mr. Antone reported that his area disseminates and shares information through email. He stated that the TCAC / CDC has developed a list serve over the years which allows for information to be readily disseminated. For specific issues such as meetings with the Tucson Area, phone calls and emails are used. Additionally, information disseminated through radio stations and public service announcements (PSAs) are used with regard to STDs and H1N1 information.

Mr. Antone shared that because the Tohono O'Odham Nation is on the Mexican border, the current most pressing issue is H1N1. He noted that the CDC guidance policies have already been disseminated and put into practice throughout his area. Another public health issue within the Nation is their on-going battle with STDs. Mr. Antone stated that they are currently observing a decrease, and with the continued efforts of CDC, TCAC, and I HS personnel, the numbers are expected to decrease even further.

One of the public health activities currently being planned in the Tucson area is a mass vaccination campaign scheduled for November 2009. Their upcoming Annual Health Fair will be moved to a different location in the hope of increasing participation. In addition, there will be a late August meeting in the Tucson area with I HS to discuss nationwide health issues.

Mr. Antone stressed that H1N1 should be a priority issue with all tribes and every effort should be made to insure that tribes are aware of the Strategic National Stockpile (SNS) and how to access it. Consideration must be given to how cities and counties will address influenza in Indian country, and how health reform will affect tribal nations. He stated that the TCAC should discuss the possibility of making an annual report to disseminate to Indian country concerning the status of the recommendations made to date, what was accomplished, what is pending, and where it is currently pending.

### **Bemidji Area**

#### **Kathy Hughes, Vice Chairwoman Oneida Business Committee**

Ms. Hughes explained that Bemidji consists of Minnesota, Michigan, Wisconsin, and Iowa and is comprised of 34 tribes that she represents. She is able to keep communications going with the tribes through a listserv because very few tribes access the CDC listserv. She acknowledged that she takes advantage of opportunities to attend regional meetings, the most significant being the Midwest Alliance of Sovereign Tribes (MAST), which meets twice a year, at which time she is given an opportunity on the agenda to update the representatives of the committees that she serves on, TCAC being one of these. She is also invited to other regional meeting such as CMS TTAG, which holds regional trainings in all of the areas. Ms. Hughes stated that the Bemidji Area training will take place the end of August in Wisconsin. She also writes a report once per month in a local newspaper which updates the areas on various committee meeting developments.

Regarding public health issues, Ms. Hughes indicated that obesity, diabetes, cardiovascular disease, and cancer still remain top priorities. To combat obesity, the Bemidji Area recently started a School Nutrition Program to begin educating the children. In addition, they have removed vending machines from the schools, and replaced unhealthy items with juices and water. Also, Oneida will host its Annual Diabetes Event where the winner from this season's "The Biggest Loser" will serve as guest speaker.

## **Navajo Area**

### **Evelyn Alcothley Navajo Health and Social Services Committee**

Ms. Alcothley indicated that she disseminates information regarding CDC by reporting to the oversight committee of the Navajo Nation Council, in addition to emailing IHS tribal programs to solicit feedback.

Public health issues identified by the Navajo Nation include:

1. The need to plan for mass vaccination for H1N1 influenza in the Fall (2009) as well as for the usual seasonal influenza.
2. The need to continue to plan for public health emergencies and bioterrorism events so that Navajo Nation will be fully prepared.
3. The need for Navajo Nation-wide disease surveillance systems (infectious disease, chronic disease, disability). Currently, no such systems exist, resulting in insufficient data to guide public health efforts to reduce morbidity, mortality, and disability on Navajo Nation.
4. The need for Data Infrastructure for the Navajo Division of Health in order to make health data available to programs and others who need to know the health status of the Navajo people.

Ms. Alcothley reported on the following public health activities currently being implemented in the Navajo Nation:

1. The Navajo Division of Health stood up its Health Command Center in April 2009 to respond to the nation-wide novel H1N1 influenza public health emergency. This Center took responsibility to update Navajo Nation on the changing status of this emergency (which became a pandemic), to respond appropriately to protect the health of the Navajo people and to work with local IHS staff (administrators, clinicians, etc.), surrounding state departments of health (Arizona, New Mexico, Utah), and the CDC to appropriately respond to this continuously changing event.
2. Navajo Division of Health Executive Director and Bioterrorism Director made an important presentation to the NIH (National Institutes of Health) concerning the Navajo Nation experience in responding to the novel H1N1 influenza emergency.
3. Navajo Division of Health has begun meeting with Navajo Area IHS and the state of Arizona to plan a novel H1N1 influenza mass vaccination in the Fall (2009). This includes setting up the first Navajo Nation-run RSS site to accept and distribute the required SNS for this important Navajo Nation-wide event.
4. Immunization against the seasonal influenza is also being planned for this Fall as well.
5. Meetings are taking place with the CDC, the HIS, and Navajo Division of Health to revise HIV / AIDS policies for Navajo Nation.
6. Meetings are taking place to convert the Navajo Division of Health to the Navajo Department of Public Health. A 2-day meeting to initiate this conversion took place in July, and staffs from several Navajo governmental organizations (e.g., Division of Justice, Division of Health, Health and Social Services Committee) are working to finalize a Navajo law that will allow this significant improvement in public health capacity for Navajo Nation to take place.

7. The first Navajo Cancer Report is being finalized and is expected to be distributed by the end of 2009.

Ms. Alcothley noted additional issues / needs that CDC and the TCAC should be aware of it as they relate to American Indian / Alaska Native people and communities:

1. There is a need for an aggressive workforce development strategy to train, recruit, and retain professionals in tribal areas. The lack of professionals provides a serious and long-term obstacle to improving tribal conditions and meeting important (and often basic) tribal needs and goals.
2. There is a need to build data infrastructure, especially within the Navajo Division of Health. All programs are in dire need of data infrastructure that will allow for the collection of tribal data (health, economic, social services, demographic, et cetera), analyze tribal data, and write and disseminate tribal reports to support AI / AN needs and goals. She requested technical assistance and resources from CDC to help build data infrastructure within the Navajo Division of Health.
3. There is a lack training for current tribal employees, especially in public health area. The Navajo are unable to provide adequate training that will prepare current and future employees to appropriately staff the new Navajo Department of Public Health as it expands to include more public health functions. She requested assistance from the CDC to train tribal employees and also provide technical assistance for our many current and planned projects.

### **California Area**

#### **James Crouch, Executive Director California Rural Indian Health Board (CRIHB)**

Mr. Crouch reported that the most impactful public health problem in California currently is the collapse of the state budget. They have seen a loss of all optional benefits under Medicaid, which means that a large amount of dental and behavioral health services will cease in their community.

In regard to H1N1, the CRIHB Medical Director, who serves half time as the Outbreak Epidemiologist for the California Tribal Epi Center, was able to receive funding for Sentinel Surveillance in three sites in Southern California, which will reach 10 specific tribal health programs throughout California to provide surveillance and supplies, and to act as a coordinating communication point with the California Department of Public Health (CDPH).

Mr. Crouch added that CRIHB was very interested in participating in the NIHB coordinated effort around Public Health Accreditation. Their Director of Family and Community Health attended the final meeting in Washington, DC in which the process was found to be very helpful. At CRIHB's recent Joint Meeting with the Northwest Portland Area Health Board, there was a morning session dealing with public health accreditation, which is garnering a great deal of interest within the State of California.

The CRIHB Department of Research has been awarded funding by the Assistant Secretary for Planning and Evaluation to build a Disparities Analysis for the I HS clients on a national basis. The purpose is to specifically conduct a comparative analysis with the Non-Hispanic Whites who live in the same zip code with the I HS clients. In addition, one of their area tribes recently received funding for their "Food is Good Medicine" program, an obesity control project. This

year they are one of four new start programs from CDC that will be receiving \$400,000 a year for four years.

Mr. Crouch highlighted several issues of concern from his area, one being that none of the I HS funded Epi Centers have regularized access to I HS data. He noted that CDC, as a sister agency, has the responsibility to push the new leadership at I HS to get in place with Health Insurance Portability and Accountability Act (HIPAA), and begin to share I HS data with the people who help to create the data, and use it for public health purposes. Secondly, Mr. Crouch expressed a lack of knowledge regarding social marketing within CRIHB, and Indian Country as a whole. He stressed that if they were going to reach diverse populations across broad regions, better tools are needed to conduct social marketing. Lastly, Mr. Crouch noted that since CRIHB has 109 recognized tribes, almost all of which have small land bases, and many of which are served in consortiums of tribal health programs under the Indian Self Determination Act, implementing public health measures is very complex. He believes that the outbreaks that they will see this fall will lead to heated moments as sovereignty collides with sovereignty. He stressed that he would like to have the health law representatives come to California to help them address the issues in advance.

### **Portland Area**

#### **Joe Finkbonner**

#### **Executive Director, Northwest Portland Area Indian Health Board (NPAIHB)**

Mr. Finkbonner highlighted several key activities from last quarter, which included the previously mentioned Joint Meeting with the California Rural Indian Health Board. He mentioned that one of the panels dealt with the tribal public health accreditation process, and what tribes can do to influence better partnership with states and locals. The following week, they had their 6<sup>th</sup> Annual Emergency Preparedness Conference, for which the keynote speaker was Dr. Evan Adams, better known as "Thomas Builds-the-Fire" from the movie Smoke Signals. Dr. Adams is an MD / MPH, is the head of First Nation's Aboriginal Health Ministry in British Columbia, and is currently working to bring their nation up to speed in the area of emergency preparedness. In addition to discussing the current infrastructure of the First Nations in British Columbia, they also discussed the impacts of the 2010 Olympics in British Columbia, and how the flu season, coupled with H1N1, would impact the event.

Mr. Finkbonner noted that six of their tribes recently received funding for a Child Safety Seat Assessment Project called "Children Always Ride Safe," which entailed conducting safety seat surveillance, as well as safety seat checks on approximately 1200 cars on six reservations. He pointed out that their presence heightened awareness concerning the proper way to install and use child safety seats, as well as tribal laws.

Smoking was also noted as a major area of concern. Mr. Finkbonner stated their tobacco program was suffering reductions in funding. Their funding comes mostly from the state from the Tobacco Settlement Suit through which funds were set aside for them to administer programs to the tribes. Congress passed a state initiative that made all public places smoke free, with the exception of tribal casinos since they are not under state jurisdiction. The governor negotiated in the Tribal Gaming Contracts that tribes would allocate some of their profits to their smoking cessation programs for each of the tribes.

Additionally, Mr. Finkbonner commented that H1N1 was a priority concern in their area. His health directors have committed to convening twice a month conference calls to prepare for the

implementation of the Pandemic Flu plans. Their first conference call will be conducted mid August to begin discussions. Also, one of their tribes has agreed to host an H1N1 fair, to disseminate information and resources to tribes.

### **Discussion Points**

- CAPT Snesrud asked the committee members to submit a written copy of their reports as soon as possible. She asked Mr. Finkbonner if he could also submit his area's Smoking Cessation report to the Office of Smoking and Health (OSH).
- Mr. Finkbonner responded that he believed their report was copied from the CDC Smoking Cessation Program. He noted that their goal was to apply it to the tribes and to successfully implement all stages of Smoking Cessation.
- Mr. Freddie commented that he had hoped to acquire information regarding the Direct Service Conference in Oklahoma City, scheduled to take place August 18-21, 2009. He stated that the NIHB also recognized the request from the land based tribes. He stressed that it was important to have key individuals such as Jody Gillette, and others within the administration meet with tribal leaders and high level officials. All of the advocates from NCAI, Self-Governance, et cetera, need to be engaged in these types of discussions. In addition, Mr. Freddie acknowledged the importance of advocating Audrey Solimon, of NIHB, and other young people from other organizations to be among the professionals working with American Indians and Alaska Natives.
- Ms. Alcotley expressed concern with H1N1 and asked how the tribes could acquire additional funding for those projects. She stated that currently the tribes are spending their funds within their areas, and budgets have been depleted.
- Mr. Antone asked if a budget request could be made to CDC.
- Dr. Bailey responded that it was appropriate to advise that funding be considered as a critical issue for Indian country, and to assess if there are other resources available. She affirmed that H1N1 funding is a major priority for President Obama, and that they are open to evaluating what other resources are needed as the season progresses. Dr. Bailey noted that it was important for the TCAC to advise CDC concerning this issue.
- Dr. Toomey added that it was her understanding that the states would be receiving funding. She noted that this is another example of where the states need to be working with tribes.
- Mr. Crouch commented that he was sure that the money they receive from the state from the -Like Illness Surveillance (ILI) and Response Program is available nationally and each state will receive funding from it. Even so, this money was not intended for the surge in individual patients. He welcomed Dr. Bailey's idea to set funds aside for surveillance, clinical level treatments, and in-patient needs.

### **Updates from CDC in Response to TCAC Recommendations**

**Captain Pelagie (Mike) Snesrud, Senior Tribal Liaison for Policy and Evaluation, CDC  
Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health, CDC**

CAPT Snesrud presented an overview of CDC responses to past TCAC recommendations, reporting that CDC responded to the following TCAC recommendations:

- **Recommendation:** Continue to fully implement the CDC Tribal Consultation Policy (TCP)
  - Response: Responsibilities to TCP implementation are established and described in the TCP itself
  - Response: CAMICC has been briefed and engaged to assist in implementation of the TCP in their national centers and offices and report back activities for inclusion in the Annual Report to OS/HHS
  - Response: Briefing has been provided to Dr. Frieden and he is supportive of CDC continued commitment to honor the government-to-government relationship of CDC with AI/AN tribes
  - Response: OMH recently developed 4 listservs to be able to consistently share and disseminate information to tribal leaders and entities
- **Recommendation:** Continue discussions with FMO to assist tribal stakeholders in understanding CDC budget formulation process and allocations
  - Response: FMO has reviewed federal budget planning process and timelines with the TCAC and has willingly agreed to participate per request of the Budget Subcommittee in any conference calls where tribal reps want to ask questions
  - Response: FMO staff (Michael Franklin) has been designated to serve as a ready resource to TCAC
- **Recommendation:** Monitor and track where tribal recommendations have influenced CDC priorities to enhance tribal access to CDC resources
  - Response: Provide agency budget allocations documents to TCAC & other tribal leaders prior to consultation sessions and strive for increased transparency of CDC allocations benefitting AI/AN tribes
  - Response: CDC/FMO/OMHD provides a slide deck each year that compares and contrasts overall categorical allocations to AI/ANs
  - Response: Developed CDC inventory of funded Tribal Programs and Projects that will be updated this FY
- **Recommendation:** Re-analyze the AI/AN Resource Allocation Portfolio such that resource allocations are stratified by categorical programs of high priority to tribes
  - Response: FMO provided comprehensive breakdown and analysis of CDC allocations benefitting tribes
  - Response: Also presented GIS maps displaying allocations by IHS and HHS Areas

- Response: Developed AI/AN Grantee Table annually since 2005
- Response: Providing greater transparency to CDC budget
- **Recommendation:** Implement standardized language for CDC FOAs that specifies tribal eligibility unless precluded by authorizing language, single eligibility approval, or similar contingencies
  - Response: Established standardized language that specifies tribal eligibility in all FOAs; Procurement and Grants Office (PGO) monitoring
- **Recommendation:** Continue to increase tribal stakeholders' knowledge of CDC funding opportunities and how to obtain TA in application process
  - Response: PGO and Extramural Offices have revised FOA templates to be clearer and simpler with another revision under way
  - Response: PGO changed the process of FOA review and approval. GMO called the Communication Control Document (CCD). As a result of CCD, the Program Offices and PGO are better able to review and ensure language is included to hold states more accountable to getting resources to tribes
  - Response: PGO providing TA training at least annually to AI / AN stakeholders
- **Recommendation:** Provide formal CDC Orientation to AI/AN stakeholders
  - Response: Offered each year during ATL based CDC Consultation Session
  - Response: Distribute a directory of CDC services, resources and SMEs to the TCAC annually
- **Recommendation:** Provide training for project officers assigned to states with established AI/AN communities
  - Response: Individual units (e.g. DCPC, OSH, DDT) provide annual training
  - Response: OWCD is responsive to having project officers across all centers/offices receive training on how to work effectively with tribal nations.
  - Response: CDC plans to continue to increase the number of project officers from different National Center (NCs)/Offices getting this training
- **Recommendation:** Advocate with NCs to continue to support and designate a certain percentage of their categorical program funds for AI / AN tribes
  - Response: Done by REACH, STEPS, DDT, OSH, Wisewoman, Cancer, Injury
  - Response: DDT / NDWP continues to partner closely with IHS, NIH, TCUs, to support tribal communities efforts. NDWP has funded 17 tribal grantees for 5 years totaling 2 million.

- **Recommendation:** For competitive applications responsive to AI / AN-focused program announcements, seek objective review panel members who are knowledgeable about working with AI/AN communities
  - Response: PGO working to develop a database of individuals with appropriate expertise and experience to serve as objective review panel members
  - Response: Have sought objective review panel members who are knowledgeable about working with AI / ANs (Diabetes, REACH, HIV / STD, OSH, DASH, Injury)
  - Response: Continue to share new tribal grantees and projects with TCAC
- **Recommendation:** Confirm that key national tribal organizations are being invited to participate in the CDC national meetings and public engagements
  - Response: NCAI, NIHB, TECs, AAIP, and I.H.S
- **Recommendation:** Reconsider decisions regarding funding for HIV and STD prevention programs in Indian country
  - Response: NCHHSTP hosted an External Consultation to address social determinants to guide their Center in development of new FOAs and policy / partnerships
  - Response: NCHHSTP committed to developing and supporting AI/AN culturally-specific best practices and initiatives
- **Recommendation:** Strengthen the relationship between DASH and tribal stakeholders to maximize resources and opportunities to address issues facing AI / AN youth
  - Response: Three tribes were funded directly for CSH
  - Response: Provides TA to BIE and Navajo Nation to conduct YRBS along with guidance offered to states and large urban areas
  - Response: NCIPC and Adolescent Goal Action Team has prioritized addressing suicide prevention in AI / AN youth
- **Recommendation:** Work together to ensure AI / AN Tribes are included in the planning of PHEP activities and events to assure a coordinated and effective public health
  - Response: COTPER / DLSR does a State-by-State review of PHEP Continuing Applications. DLSR reviews applications for Tribal Inclusions, concurrence, involvement in planning, and implementation of activities
- **Recommendation:** Assure that CDC Director and other executive leadership responds in a timely and effective manner to recommendations
  - Response: Dr. Bailey will update CDC leadership periodically on CDC implementation of the TCP and responses to TCAC

- Response: STLs housed in OCPHP / OMHD. Dr. Bailey has established a OCPHP Triage Team that is engaging CDC leadership and operating units to institute actions and more timely resources

CAPT Snesrud acknowledged that there was an incredible amount of activity taking place across the agency concerning tribes that is not effectively coordinated with what the TCAC has prescribed. She stressed that this was something CDC is working diligently to modify.

Dr. Bryan added that CDC was in the middle of an Organizational Improvement Process, which was going to result in changes in the Office of the Director (OD), as well as the center structure. As CDC goes through this process, and there is the creation of several new organizational units that may focus on state, local and tribal support, there may be more opportunities to consider how their tribal support functions work.

CAPT Snesrud further stated that OD/OCPHP/OMHD should be receiving the request from OS/HHS/IGA for the Agency Annual Tribal Budget and Consultation Report in October. She mentioned one of the goals is to ensure that the report is a comprehensive compilation of the work that CDC is conducting with Indian country, so that it can serve as a resource document for tribal leaders.

### **Discussion Points**

#### **Recommendation**

- Mr. Jasper commented that even though CDC is a funding source for tribes and tribal organizations, it would be beneficial to have access to some of the expertise that CDC has. As USET develops methodologies to collect and analyze data, and develop statistical reports, it would be ideal to have an expert verify the work for flaws.
- Commander Billie highlighted collaborative efforts the National Center for Injury Prevention and Control (NCIPC) has had with tribes. There was funding specifically set aside for tribes to apply for Motor Vehicle Crash Prevention Funding. Four tribes were funded, which include San Carlos Apache, White Mountain Apache, Tohono O'Odham Nation, and Ho-Chunk Nation. Commander Billie mentioned that the tribes were initially funded for four years, but since things went so well, they received an additional year of funding. These projects were very successful in addressing the improvement of seat belt use, car seat use, and lowering DUI-related crashes. She noted that her center is in the process of enhancing their website to highlight these tribes, in addition to many other efforts. They are also developing a Lessons Learned for tribes to utilize, which will be released in a few months. Additionally, Commander Billie stated that her center is currently attempting to form a major collaboration that involves the National Highway Traffic Administration, the Bureau of Indian Affairs (BIA), I HS, and CDC to publish a major RFP to get funding to the tribes.
- Dr. Bailey pointed out the need to focus on what happens when the funding runs out. Has the behavior changed? She noted that sustainability should be a priority area of focus that does not stop when the funding stops. The charge for CDC is to determine how to keep the momentum going.
- Commander Billie responded that two of the grantees were able to keep the programs going. Because the programs were such major successes, the tribes themselves decided to fund the programs for an additional year.

- Ms. Hughes commented that it is helpful that this information will appear on the webpage since tribes still do not know what is available from CDC. Therefore, having a website to distinguish which tribes have received funding and how they have used it is very beneficial. It will also give them an idea of how to put their proposals together, and access CDC funding.
- CDR Billie added that she could provide the TCAC with a copy of the highlights if needed.

## CDC Budget Updates

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

Mr. Curlee welcomed the group and stated that his goal was to offer an overview of CDC / ATSDR resources committed to programs that benefit American Indians / Alaska Native populations and communities. The fiscal information was summarized according to organizational and disease-specific programs and by defined funding categories.

As of August 2009, CDC / ATSDR allocated \$16.9 million dollars of funding to AI / AN programs. Of those dollars, \$14.8 million was allocated to the Coordinating Center for Health Promotion, \$1.7 million to the Coordinating Center for Infectious Disease, \$288,000 to the Office of Minority Health, and \$59,000 to ATSDR. Some of the AI / AN disease-specific programs that received funding included HIV Prevention, Viral Hepatitis, Healthy Lifestyles, Diabetes Prevention, Breast and Cervical Cancer Prevention, and Integrated Preventive Healthcare for Women (WISEWOMAN). The total funding in this area to date is \$3.6 million.

The total American Indian / Alaska Native funding for FY 2008, including the VFC program was \$108,761,776. Non-VFC funding was \$44,497,875, or 41% of the total funding. The \$44 million of non-VFC funding represents an increase from FY 2007. The VFC funding level decreased, given that CDC's entire budget was decreased. Mr. Curlee noted that these figures included all funding categories, including grants, cooperative agreements, resource allocations, and grants to states that benefit tribes. Not including VFC, Chronic Disease Prevention and Health Promotion programs comprised the highest percentage of American Indian / Alaska Native total funds.

Mr. Curlee indicated that there are five Funding Allocation Categories:

- AI / AN Awardees (Direct): Competitively awarded programs (i.e., grants, cooperative agreements) where the awardees' is a tribe / tribal government, tribal organization, tribal epidemiology, Alaska Native organization, tribal college, university, or urban Indian Health program.
- Intramural AI / AN: Intramural programs whose purpose is to primarily or substantially benefit AI / AN. This category would include costs [salary, fringe, travel, et cetera] associated with CDC staff or contractors whose time/effort primarily or substantially (50% or better) benefit AI / AN.
- Extramural AI / AN Benefit: Competitively awarded programs where the purpose of the award is to primarily or substantially benefit AI / AN.

- Federal AI / AN Benefit: Federal Intra-Agency Agreements where the purpose of the agreement is to primarily or substantially benefit AI / AN.
- Indirect AI/AN: Service programs where funding for AI / ANs can reasonably be estimated from available data on the number of AI / ANs served. This category applies only to the Vaccines for Children program and to NCHS.

Including VFC, most funding to tribes was through indirect means. Without VFC, 52% of the funding allocation was via American Indian / Alaska Native awardees. The funding allocations for FY 07 and FY 08 include the following:

Funding Allocation Category	With VFC		Percent Change	Without VFC		Percent Change
	FY 2007	FY 2008		FY 2007	FY 2008	
Federal AI/AN	\$1,963,397	\$2,006,435	2%	\$1,963,397	\$2,006,435	2%
Intramural	\$6,910,766	\$6,856,724	-1%	\$6,910,766	\$6,856,724	-1%
Extramural AI/AN	\$9,500,990	\$10,687,986	12%	\$9,500,990	\$10,687,986	12%
AI/AN Awardee	\$21,948,174	\$22,839,514	4%	\$21,948,174	\$22,839,514	4%
Indirect	\$70,718,481	\$65,688,647	-7%	\$1,571,627	\$1,424,746	-9%
<b>CDC Grand Total</b>	<b>\$111,041,808</b>	<b>\$108,079,306</b>	<b>-2.7%</b>	<b>\$41,894,954</b>	<b>\$43,815,405</b>	<b>4.6%</b>

Mr. Curlee noted that the President's budget may offer more opportunities for funding for the upcoming year in the areas of Cancer and Diabetes. In addition, there is an increase in the Emergency Preparedness grants due to H1N1.

CDC engages in a planning process before the new fiscal year begins. Given the new administration and President's budget, he is hopeful that the program offices will work toward new grant opportunities. In addition, the Procurement and Grants Office made a major emphasis on planning early for 2010 so that they could plan for a level of effort, and work on important dates. Thirdly, CDC is moving diligently to award more funding earlier than waiting until the fourth quarter. Therefore, much emphasis needs to be placed on future funding.

In regards to the FY 2011 process, Mr. Curlee stated that CDC is in the process of getting ready to submit their Office of Management and Budget (OMB) Budget Submissions. He noted the importance of elaborating on the important health areas, Chronic Disease being one of the key priority areas. He mentioned that budget information would not be made public until the first Monday in February 2010, the date the President's budget was due. However, he acknowledged that Dr. Frieden was working diligently to try to promote funding for key priority areas such as health disparities.

Other TCAC CDC / ATSDR funding strategies noted by Mr. Curlee included expanding division-based involvement for health impact across CDC / ATSDR, developing a program project initiative with CDC / ATSDR Financial Strategies Committee, increasing visibility in budget submission health initiatives, aligning with CDC / ATSDR health goals and objectives for performance and results based management, and collaborating further with HHS and OPDIV shared resource initiatives.

### **Discussion Points**

- Dr. Bailey asked why there was a 21% decrease in funding for AI / ANs in the area of Infectious Disease.
- Mr. Curlee replied that he did not know specifically but could provide the information at a later date. He noted that it could be a number of reasons including a cycle change, decrease in grant funding, et cetera.
- CAPT Snesrud responded that the decrease in funding was due to a Cooperative Agreement that was funded for a five-year period of time that ended. She stressed the importance of analyzing the trends based on what the public health priorities were.
- Mr. Gilbert asked if this information represent funds that go directly to tribes or funding tribes might get through the states.
- CAPT Snesrud indicated that these are not just direct awards, but funds derived from the five categorical areas: direct, indirect, intramural, extramural, and federal.
- Dr. Toomey added that based on her experience with the states, these probably do not include state grants to other entities, unless it is a direct pass-through to a specific entity. She added that all of the New Mexico grants that the state gives probably do not show up in these categories.
- Dr. Bryan responded that part of their data collection process represents what the programs tell them regarding what awards have been given to states, academic institutions, et cetera, that they can document substantially benefit AI / AN populations. Therefore, some of the data that programs put in those categories could have ended up under Infectious Disease in Alaska. However, it does not represent those broad, larger state-based awards that do not fall into that category.
- Dr. Bryan explained that the extramural category reflects what the NCs and their programs have identified as funds allocated given to states, academic institutions, et cetera, that they can document substantially benefit AI / AN populations. He noted that the figures from DSLR would fall into this category, not necessarily into the infectious disease category.
- Mr. Antone commented that it would be beneficial to have the COTPER/DSLR project officers at the next meeting to describe what monies tribes get within individual states they work with under PHEP awards. He noted that this was a question that previously came up regarding pass through funds, and CDC guidance pertaining to those funds.
- Dr. Bailey asked if the awardee categories were distinct, with no duplication within each category.

- Dr. Bryan explained that when they receive the list of awardees from the program and PGO, the lists are meshed together. Currently, this process is simply a labor-intensive hand tally that FMO and OMHD conducts to ensure the categories are appropriately assigned.
- Mr. Jasper asked if they were able to project funding for the Tribal Epidemiology Centers for 2010. He commented that in 2009, his area received \$100,000 from CDC. However, last year they did not receive any, and he believes that are projected not to receive any funding again this year.
- Mr. Crouch comment there was year-end money from IHS, but he is not aware of any other funds.
- Dr. Bryan replied that the Epi Centers that are receiving funding, that are in the midst of the five-year blocks, will likely continue to receive funding. Developmentally, CDC has thoughts about how they could potentially support the centers in the future; however, there is no information available beyond the deliberative process just yet.
- CAPT Snesrud affirmed that there was a three-year Infant Mortality grant through which \$1.5 million was allocated to 7 of the Tribal Epi Centers. This was actually the only time that occurred. Other than that, CDC's awards to the Tribal Epi Centers have been through individual FOA applications / awards to Epicenters that applied and competed successfully.
- Dr. Bryan stressed that CDC allocates funding to the Tribal Epi Centers the best way they can. He noted that what Mr. Jasper was referring to was just one of the mechanisms that happened to have gone through CDC's relationship with IHS.
- Ms. Hughes asked what timeline tribes should focus on to have an impact on the FY2011 budget, and whether January was too early to begin discussions.
- Mr. Curlee responded that January was too late. The budgets for FY 2010 were begun 18 months to two years ago. To increase visibility, tribes should start working immediately to affect the budget. However, they cannot expect to realize the "fruits of their labor" for 18 months to two years. CDC and HHS can work on four or five years' of budgets at a time. Usually, the planning process at CDC begins in January or February of the calendar year. The 9 Coordinating Centers of CDC are also planning. Engagement with partners should start at the beginning of the calendar year, therefore. The OMB forwards its guidance to HHS in the spring, and HHS passes it through to CDC. The Coordinating Centers of CDC then respond to the guidance. By the fall, OMB responds, and there is usually a soft agreement from OMB regarding the budget by the end of the year. In the beginning of 2010, they will be considering the 2012 budget. Next, the budget is sent to Congressional Committees. They review all budgets from all agencies. They can add and remove items from the budgets as well as add stipulations for where funds will be spent. This process takes place in January or February. By July, OMB has approved the Congressional changes. In September, the President should be able to sign the Appropriations Act; however, the signing rarely takes place in September. In this case, the budget goes into a Continuing Resolution in order for the government to keep operating. He noted that it is important for tribes to understand when their partners are planning and when Congress is reviewing budgets. When the Coordinating Centers are planning, tribes should be actively engaged with them and with their partners. CDC has Executive-level committees, including the Executive Leadership Board (ELB) and the Financial Strategy Committee (FSC). Mr.

Curlee suggested that tribes work with those groups to present their suggestions about the impact of CDC dollars on tribes. The dollars are getting smaller, and they have to plan better and prioritize their needs for the long-term. Tribes should show CDC where their needs are greatest.

- Mr. Crouch commented that the TCAC dealt with the budget in Tuscan, and a lot of comments were made. Tribes are hoping that the agency's interest in expanding and investing in the Indian community is brought forward. TCAC is able to communicate budgetary concerns through the HHS Secretary, or perhaps even through the White House; however, the energy spent prevents them from thinking about the material they need to be thinking about for 2012.
- Ms. Hughes added that as an advisory committee, TCAC should be submitting recommendations to CDC, as well as determining the appropriate time to do so.
- Mr. Crouch responded that the funding cycle was easy to understand because it tracks with the IHS cycle; however, the problem is the mechanism for having impact. He said that as a committee member, there should be more a formal ways of saying "these are the things that scare us and you should look into this."
- Dr. Bailey mentioned that her first meeting with ICNAA was this past spring where all of the Secretary's Optives came together to hear from Indian country. She thought that this process should help form the Secretary's budget.
- Mr. Crouch stated that maybe the TCAC could have a conference call in the next week or two to develop a short list of investments. There need to be more direct ways to get TCAC input into the budget planning process.
- Mr. Jasper agreed. He stated that he served on the National Budget Formulation Committee with IHS for many years. Budget Formulation is only one part of the process, and many of the priorities are fairly broad. He stressed the importance of not losing sight of having input into budget execution. When all of the agencies receive their appropriations, there are some decisions that can be made within those options to stay within the broad stroke, within the main objectives, and still provide some specific funding for targeted activities. There might be opportunities where TCAC may have opportunities for impact for 2010.
- Mr. Curlee acknowledged that this was a very good point. Even though the formulation process is going to go through, and 2010 is "right around the corner," it is an opportunity to be more clarified with certain issues. He pointed out that there are still opportunities and flexibilities were performance cycles have changed, or performances were not up to standard, and they can look toward initiatives to Indian country support for 2011. Additionally, he indicated that 2012 and 2013 are going to be landmarks points for President and what is established because it will be the middle of the Presidency, and he will be looking for key initiatives in the public health arena.
- Dr. Bailey asked if it would be advisable to create a list of what would be appropriate for end of the year funding specifically beneficial to AI / ANs.

- Mr. Curlee replied that sometimes CDC has some funding that is identified after closing timelines have been passed. The key is already having projects identified and mechanisms already in place.
- Mr. Gilbert remembered having a similar discussion in Tucson regarding budgets, and noted that it was frustrating that the committee was going over this information again. He thought that the committee lacked a strategy regarding how they would deal with the issue. He thought that Indian country should discuss this as a committee to look at the next opportunity to have input about how they can influence how CDC forms their budget. Indian country benefits from year-end money largely because they have a certain capacity within their system and relationships with CDC. The greater payoffs are the larger, multi-year projects currently being competed for. If the TCAC is going to talk about a strategy, it needs to be written with specific areas of interest (e.g., year-end money, multi-year projects, attend DHHS Consultation, co-chair testimonies, et cetera). SAMSHA is one of the agencies within Indian country that received an increase in funding due to Dr. Broderick. There is something that TCAC could learn from the other three advisory groups to accomplish the same objectives, which is primarily to increase resources. He urged the committee to discontinue inundating Dr. Bryan and CAPT Snedrud with “busy work” and instead try to utilize them to help develop a strategic plan for 2012.
- Mr. Crouch commented that the budget formulation and planning process was hard work, which takes a lot of time and discussion. He noted that one of the things that make it more complex is the decision to augment what IHS is already providing, or concentrate on those things that CDC uniquely does that might bring about new opportunities within Indian country. It is important to spend enough time with the budget materials to understand what CDC does. He stressed that it was going to take time; however, every year the committee attempts to accomplish it within a cycle.
- Mr. Valdo commented that the difference at SAMSHA is Dr. Broderick because he knows how to push funding. He mentioned that SAMSHA has a State Tribal Relations Committee that actually goes to states and have solicited their help. In addition, tribes access SAMSHA a lot more than they do CDC.
- Mr. Crouch responded that Indian country is not very familiar with CDC, which is much more complex than SAMSHA. He declared that his time served on the TCAC has been a learning curve, and that “mastering the menu” has taking a certain amount of time. The next step is to figure out where TCAC can spend the time to develop a strategic plan, and have it appropriately submitted.
- Mr. Gilbert reemphasized the importance of strategizing. He suggested that part of that strategy could be to create a champion in the new CDC Director. He asked what the value would be in organizing a meeting of SAMSHA leadership with CDC leadership to discuss the successes of SAMSHA in Indian country. In addition, Mr. Gilbert noted that his organization is very active in Alaska with their delegation, and if TCAC were to develop TCAC priorities for 2012, and put that information in the hands of his delegation, the information would be disseminated faster. He urged the TCAC to be more strategic to increase its resources.
- Dr. Bryan affirmed that the committee has received a lot of information concerning Suicide and Behavioral Health Issues, and these interface a lot with SAMSHA. Suicide is profound,

and if one was to evaluate CDC's fiscal investment in that area, it would be considered "meager" compared to the size of the problem. He agreed with Mr. Gilbert's suggestion of interfacing more with SAMSHA, and noted that it would be timely to get an recommendation from the committee to suggest that in terms of how the TCAC assesses the issues, and how they might work together programmatically and budget wise.

#### **Recommendation**

- Mr. James Crouch, Executive Director, California Rural Indian Health Board (CRIHB) made a recommendation to bring SAMSHA and CDC leadership together to consider programming in Indian country with an agenda to increase investment in Suicide Prevention and other common areas where there might be common work.
- Dr. Bailey believed the recommendation was appropriate since Dr. Frieden's intention to create agendas was a top priority; she noted that a lead person to cause those conversations to happen would be needed.
- Mr. Antone indicated that he would be attending an upcoming SAMSHA meeting in September and would be more than happy to present the recommendation to the committee during that time.
- Mr. Freddie commented that since there is new membership, there is a need for a refresher course, possibly CDC 101. Secondly, knowing and understanding the budget within a program is key to making good recommendations. A good overview of the CDC budget, and where the need is for Indian country should be reflected during the orientation. From there, TCAC can determine priority areas, such as suicide, H1N1, health reform, et cetera.

### **Novel H1N1 Influenza Update and Vaccine Distribution Discussion**

#### **Dr. Jay Butler, Director, H1N1 Task Force Centers for Disease Control and Prevention**

Dr. Butler thanked the group for the opportunity to present a brief overview of H1N1 by way of updates regarding epidemiology of the disease, and to discuss the effects of the vaccine policies. He believes H1N1 planning has paid off and that failures are related to where planning has not taken place as adequately as possible. The situation the country is facing is not necessarily the situation CDC planned for because the illness is not as severe as the 1918 scenario in which fatalities were estimated to be between 1% to 2%. The H1N1 fatality rate is one tenth of that. Secondly, the epidemiology of the disease is different. The fact that elders would be spared from the virus was not incorporated into the planning. Pre-Pandemic Guidance on Vaccine Allocation focused on critical infrastructure protection and assumed that the elderly would be an at-risk population. The behavior of the disease is not suggesting that critical infrastructure staff must be kept well so that they can continue to work or that elders are going to be at high risk. Conversely, the epidemiology suggests that the young people are at higher risk, and that if there is a threat to infrastructure, it is because people have to stay home with their children when they are sick or when school is closed.

In addition, for most of the country, there was not much lead time because the disease began in North America. Much of the planning was based on the 1968 Hong Kong Flu, the Asian Flu, H5N1, and other Asian strains. Another indication of good planning is that it is very likely that CDC will have larger amounts of vaccine available than included in planning scenarios, which has driven many decisions concerning distribution. For H5N1, it was assumed that the vaccine would be in very limited supply and it would come from one manufacturer. For H1N1, the government has already purchased 195 million doses from 5 different manufacturers, so while the government has an abundance of the H1N1 vaccine, it is going to be a major asset to handle. Lastly, the one thing that was not built into the planning was the confluence of seasonal pandemic vaccination in the Fall of 2009. The upcoming flu season could be similar to the 1918 scenario as time progresses. Historical records show that mild disease occurred in the Spring and to some degree in the Summer of 1918, and then in the Fall there was a resurgence of the virus with a vengeance. Heavy surveillance of H1N1 has not shown any evidence of this occurring in the Fall of 2009. Some communities have been highly impacted by the virus. However, others, for whatever reason have not been widely impacted. The virus has now spread to over 160 countries nationally. Mortality has been documented in most places where there is good surveillance. It is difficult to determine how much the virus has spread in Africa, because many African countries do not have diagnostic capabilities. Based on the criteria set forth by the World Health Organization (WHO), H1N1 is a Phase 6 Pandemic.

The risk groups for H1N1 include children; however, people with certain underlying conditions are disproportionately impacted. The highest incidence of lab-confirmed infections occurred in school aged children. The highest hospitalization rates occurred among children 0 to 4 years old. Hospitalization rates for the first three months of the outbreak approach cumulative rates for seasonal influenza among school-aged children and among younger adults, and the fewest cases, but highest case-fatality ratio, is in older adults. In addition, there are a higher proportion of hospitalized cases in children and young adults, fewer cases found in older adults, and no outbreaks among elderly in long-term care facilities. Of the hospitalized cases, 70% have had an underlying medical condition that confers higher risk or complications. Novel H1N1 virus has shown no significant antigenic changes since April 2009. The testing of the hemagglutinin suggests that it is very similar to the H1 subtype viruses circulated during the 1940s. Cross-reactive antibody to novel H1N1 was detected among adults participants in vaccine studies. CDC is awaiting clinical studies to determine whether older adults with some pre-existing immunity might need a single dose.

CDC has provided school strategies that include staying at home when sick, separating ill students and staff, washing hands, covering coughs and sneezes, prompting treatment of high risk students and staff, routine cleaning, and consideration of selective school dismissal. In addition, CDC recognized key messages for communities which include strengthening monitoring systems, preparing vaccination campaigns, preparing for medical care, being flexible and ready to adapt to the unexpected, preparing communications, and supporting localities to do all of the above.

CDC's Advisory Committee on Immunization Practices (ACIP) concluded that within the first few weeks, the H1N1 supply might be limited, but all indications are that there will be an abundant supply. The groups recommended to get the vaccines first are children 6 months through 24 years, which represents approximately 102 million people; adults 26 to 34 years of age with high risk medical conditions; health care providers, including emergency medical services personnel (represents about 14 million people); people who have household contact with infants less than 5 months of age (represents 5 million); and pregnant women, who represent approximately 4 million people. It is expected that as time progresses, the vaccine will be more widely available;

thus, adults ages 25 through 64 can be vaccinated, followed eventually by adults 65 years and older.

Dr. Butler discussed the challenges to making vaccine recommendations, which include persistent transmission in the US since the introduction of H1N1, and potential for second surge in incidence; the need for vaccine clinical trials and mass production to proceed simultaneously; the need for recommendations for use to be made before licensure to provide basis for implementation planning; and uncertainty of arrival date of vaccines, amount of vaccines, if pace supply will increase over time, and its ability to implement recommendations are all challenges to making vaccine recommendations.

In addition, Dr. Butler mentioned several challenges to H1N1 response which include the virus's potential to change to be more deadly, vaccine production and distribution, the likely need for a two-dose series, and suspicion about vaccines. Additionally, public health infrastructure poses a challenge due to decades of neglect, and the current fiscal crisis. Health care can also pose a challenge in H1N1 response due to poor coordination efforts, lack of good information systems, and lack of prevention infrastructure or focus. Finally, coordination across governments may potentially pose a challenge to future H1N1 response.

### **Discussion Points**

- Deborah Claus asked if distribution of the vaccines would be through the states.
- Dr. Butler replied that distribution would be conducted through the states. The system for distributing vaccine will be the same as that used for the VFC program.
- Dr. Hennessy mentioned that there was a Novel Influenza Surveillance System (NISS). The IHS Service Epi Team in Albuquerque developed a patch that can be applied to the RPMS Data Monitoring System that can screen for Influenza like illness in tribal health systems that are using RPMS to scan their patient visitation, and be able to catalogue on a daily basis to determine how many people are coming into the health centers with influenza-like symptoms, and be able to track this information over time. He held that the system was far superior to what is typically used for ILI surveillance where providers report on a weekly basis because it is automated data already being collected within the health service unit. If tribes are interested, tribal or I HS facilities will already have the capacity. All they have to do is turn on the RPMS patch, the programming has already been done by the group in Albuquerque. This is a fantastic tool and will provide a leap forward in surveillance among tribal populations that we have not had in the past.
- Mr. Jasper asked if that was a patch to the current immunization package that had already been released.
- Dr. Bryan replied that it was not. It is ICD-9 code based.
- Ms. Hughes was told that in Wisconsin, distribution would go directly to the tribes. She suggested that it would be helpful for CDC to reach out to confirm what the states are doing to contact with the tribes. Additionally, they are expecting to distribute vaccines to everyone immediately because they fall into the high risk groups.

- Dr. Butler responded that if the supply is adequate, that would be an ideal situation. He stressed that CDC is trying to avoid a 2004 situation where during which there was a vaccine shortage. There was a complicated prioritization system set up, in addition to a large part of the community encouraging people not to get the vaccine. The result was that some people who really needed the vaccine did not get it, and the shortage turned into people not getting vaccinated at all. He asked whether vaccine would come directly to them from the distributor.
- Ms. Hughes replied that it would.
- Dr. Butler commented that this was a good example of what is functional in many areas. He stressed that there was no right way to do this. The advantage of the system that is being created is that it offers a lot of flexibility. In Alaska, there will more than likely be only one shipment site, which will be into the Vaccine Depot, who will then distribute the vaccine to providers, and then work with the tribal consortium. Other states will probably have thousands of receiving sites.
- Dr. Bailey noted that she wanted to put H1N1 “on CDC’s plate” in terms of coordination. She recently had a meeting with the local Anchorage Health Department and the State of Alaska during which one issues raised regarded I HS sending their own antivirals and post-exposure prophylaxis (PEP) to tribes and asking them for addresses, which could be potentially conflicting to local communities. Additionally, DOD and FEMA are in the process of creating an H1N1 strategic plan to distribute to Indian country, and CDC should be involved in these coordination efforts.
- Dr. Butler asked if the antivirals were SNS assets or purchased assets.
- Dr. Bailey responded that she understood them to be SNS assets, which is where the conflict arises. She suggested that Dr. Butler may want to check with I HS to determine what exactly is being done with the tribes. During the outbreaks that were occurring, the Alaska health organizations were receiving daily calls from people within CDC. She stressed this was an issue that desperately needed to be addressed during their next exercise.
- Mr. Finkbonner commented that in the Portland area, I HS coordinated an additional purchase of the antiviral supply for the tribes that requested it. Washington and Iowa also extended the offer to acquire contract pharmaceuticals through the federal rate that was provided to the states for purchasing their individual stockpile. Both of those avenues were available to the tribes in Washington and Oregon.

### **Tribal Public Health Accreditation**

**Ileen Sylvester, Vice-President for Executive and Tribal Services,  
South Central Foundation**

**Ms. Sally Smith, Chair, Bristol Bay Area Health Corporation,  
Board of Directors**

Ms. Sally Smith welcomed the group and addressed the need for exploring tribal public health accreditation. Ms. Smith stated that the Public Health Accreditation Board (PHAB) is dedicated to raising the standard for public health. With support from the CDC and The Robert Wood Johnson (RWJ) Foundation, they work with leading public health experts from the field to develop a voluntary national accreditation program that will help public health departments assess their current capacity and guide them to become even better providers of quality service, thus promoting a healthier public. In an effort to align national standards with the needs of members and address a wide range of public health department structures and circumstances across the country, PHAB works closely with NACCHO, ASTHO and NALBOH. The standards include:

- Monitoring health status and understanding issues
- Protecting people from health problems and health hazards
- Giving people information they need to make healthy choices
- Engaging the community to identify and solve health problems
- Developing public health policies and plans
- Enforcing public health laws and regulations
- Helping people receive health services
- Maintaining a competent public health workforce
- Evaluating and improving the quality of programs and interventions
- Contributing to and applying the evidence base of public health
- Governing and managing health department resources (including financial and human resources, facilities and information systems)

In addition, the PHAB has also created several committees and workgroups comprised primarily of state and local health officials to develop all aspects of the new accreditation program. These expert workgroups and committees are developing the features of the new accreditation program building on the excellent work of others who have addressed performance improvement and existing state-based performance standard programs. NIHB is currently exploring the idea of public health accreditation.

The objectives of the NIHB project are to establish an advisory panel, review past accreditation efforts in Indian country, explore and discuss the potential for voluntary public health accreditation in Indian country, and gather recommendations. NIHB's progress with the accreditation project to date includes establishment of advisory board with tribal representatives from the 11 I.H.S. service areas, National Tribal Call for Input closed on May 31, 2009, the Strategic Plan was finalized on July 1, 2009, and NIHB recently signed an MOU with PHAB to continue NIHB's involvement in accreditation. The accreditation process is to be implemented in 2011.

### **Discussion Points**

- Mr. Crouch commented that their Department of Family and Community Health has been the lead inside of the California Rural Indian Health Board, where very robust discussions have taken place during a recent meeting between the two organizations. Within the dominant society, the entire concept of public health atrophied over the last decade, and even though the IHS has the best health politics in the world, the truth is that there have been so few resources coming into the systems, part of what has atrophied has been the "real guts" of the public health program in tribal health settings. He explained that "guts" referred to the public health nurse, CHRs, and the relationship between those two

components. What he really likes about the Public Health Accreditation Program is that for tribal programs, it is a place where they can refocus on the definitional nature of what public health work is. This process is a great way for Indian country to become more aware of modern public health.

- Ms. Hughes indicated that the deadline to apply was unfortunately August 14, 2009.
- Ms. Smith indicated that there was a strong possibility that the deadline would be extended.

## **NCEH / ATSDR Office of Tribal Affairs (OTA) Updates**

### **Office of Tribal Affairs Partnerships**

**Annabelle Allison, Environmental Health Scientist  
NCEH/ATSDR Office of Tribal Affairs (OTA)**

**Richard Kauffman, Senior Regional Representative  
ATSDR / Region 10**

Ms. Allison thanked the group for allowing her to share information concerning partnerships that the Office of Tribal Affairs currently has with several national Tribal environmental organizations. She indicated that NCEH just recently established a Climate Change Program, which focuses on global and urban work. She pointed out that it behooved NCEH to include tribes, and to gain their insight, and perspectives in having to deal with this issue.

She introduced Richard Kauffman, Senior Regional Representative, NCEH / ATSDR Office of Tribal Affairs. Mr. Kauffman reported that ATSDR was created in 1980 by the Superfund Act and was tasked to "prevent or mitigate adverse human health effects [from] hazardous substances." They are headquartered in Atlanta, Georgia and currently have 11 regional offices, 2 state offices (Alaska and Montana), and 31 state cooperative agreements. ATSDR's role is to evaluate human exposures to contaminants; conduct public health assessments; provide health consultations; and provide exposure investigation, health education, and resources on toxins.

Requests are made to ATSDR by letter, email, or phone call. Any agency, non-profit, government, community, tribe, or individual can request assistance ATSDR. Requests are evaluated for urgency, appropriateness, availability of data, and availability of funds. If a request is accepted, ATSDR works to determine the appropriate response. Health assessments, consultations, exposure investigations, or technical assistance are possible responses to requests. The work is conducted by the ATSDR Regional office, ATSDR Headquarters, or Alaska Health Department. If request cannot be accepted, the Alaska Regional Representative will continue to work with to answer questions and find other resources to assist. Several reasons why requests are not accepted are due to a lack of data, funding limitations, if a request is not site-specific, and issues related to oil and petroleum, which ATSDR is specifically excluded from addressing under the Superfund Act. ATSDR looks forward to their new partnership with NCEH which will enable them to address issues related to oil.

Health assessments are a major function of ATSDR. They are a multi-step process that includes community input and gathering and evaluating data and exposure pathways, which is the key point in the process that determines the outcome. Exposure pathways pertain to how the chemicals ultimately get from the source in the environment into the bodies of the people who might be exposed. To determine if someone is exposed, ATSDR begins with screenings to compare numbers to guidelines, similar to the Environmental Protection Agency / Department of Environmental Conservation (EPA / DEC) risk assessments. They end with an in-depth analysis, and careful review of data, community, site and current literature. The final step is to draw conclusions, make recommendations, and develop a Public Health Action Plan where they work with all partners to make sure the recommendations made by ATSDR are implemented.

For issues that are not as comprehensive as required in a health assessment, technical assistance mechanisms are available. Technical assistance is provided when there are questions about specific contaminants, such as PCBs, Mercury, and Creosote. In addition, ATSDR provides assistance in transporting contaminants, designing environmental sampling, and survey design.

Current activities conducted by ATSDR in the Alaska region include facilitating involvement in DOD sites, health impact assessments, large natural resource developments, Brownfields assessment, assist partners in incorporating health in redevelopment project, and developing relationships with UAA and UAF.

ATSDR Regional Office's goal is to improve health and environmental collaborations. The agency works diligently with federal, state, and tribal partners to address environmental concerns.

### **Health Studies Branch (HSB) Environmental Health Program**

**Paul Melstrom, PhD**  
**Division of Environmental and Health Effects, NCEH**

**Matthew Murphy, MS, PhD**  
**Division of Environmental and Health Effects, NCEH**

Ms. Allison introduced Drs. Paul Melstrom and Matthew Murphy of NCEH. Dr. Melstrom welcomed the group and thanked them for the opportunity to present on behalf of HSB. He indicated that the purpose of their talk was to provide examples of current and past projects that their branch has engaged in, and to provide an overview of what assets HSB has available to conduct public health programs related to the environmental concerns of American Indian / Alaskan Native communities. Above all, their primary objective was to listen to the TCAC's ideas about issues that are important to the people whom they represent.

Dr. Melstrom stated that there are three primary missions of the Health Studies Branch (HSB), one of which is to conduct planned studies to address environmental threats. For example, in Kenya, there was a recurrent problem of a fungal infection in the grain. The fungus produced a toxin, called an aflatoxin, which was making people very sick. HSB developed a laboratory test to detect the presence of this toxin so people could avoid the contaminated grain. This was an example in which a million dollar solution would not work because the population had no running water or electricity, and therefore no laboratory.

HSB also investigates outbreaks of environmental and chemical origins, 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.

Some example projects that HSB has completed or that are in progress with Native American communities is the Walker River Paiute Tribe, who had reported high levels of arsenic in their drinking water, and needed to determine if it would be worth the expense to install a community drinking water system. HSB tested the community's water sources, and acquired urine samples from volunteers to assess whether the tribe's exposure levels were unacceptably high. HSB found that arsenic levels were, indeed, high and that 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 obtain 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 that those who consumed more local fish had higher levels of mercury.

To date, the largest study HSB has conducted was on the largest reservation in the US, the Navajo Nation. Dr. Murphy stated that water hauling is widespread within the Navajo Nation, and roughly 14,000 households are without potable water. The goals of their study were to investigate the use of unregulated and untreated source water; investigate water storage and handling; determine to what extent contamination of unregulated water sources represents a public health threat; and 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.

Dr. Murphy indicated that HSB found a considerable proportion of households (22%) haul water, including some with access to public water. In addition, those who hauled water were more likely to be exposed to bacterial contaminants in drinking water. They also found urine uranium levels were higher than in 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.

In addition, HSB implemented an Arctic Health Program, through which the branch funded discrete long-term studies to investigate environmental exposures and health. New approaches include building capacity for environmental epidemiology through staff development, implementation 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 TCAC to provide insight into additional environmental health focus areas to consider.

### **Discussion Points**

- Mr. Freddie remarked that the presentation was excellent, and extended a request Dr. Murphy to attend one of their committee meetings. He pointed out that within Navajo, much of the focus on health care is on the clinical side, and now it is shifting to public health. When he was growing up, he would go to a cow track and drink from a small puddle of water without getting sick or going to the clinic. He stressed that his people were vulnerable and susceptible to many things now. IHS and other agencies will tell them that it is too costly to treat the water. Climate change is another issue in his area. They have been in a draught situation in his area for some time. Erosion is also a major problem, as is over-grazing. No rain until fall and winter could have major impact on the livestock industry. There are too many horses on reservations as well. While they do not want to destroy the horses through slaughterhouses, and there is an overstocking problem that is likely to impact the land and air. Botulism is another crisis that will result. He stressed the importance of these types of studies.
- Ms. Alcotley commented that water is a major concern to Navajo because of droughts and contamination. In the communities she represents, the Resource Committee of Navajo Nation Council met to address concerns with water in that the water storage units were labeled unsafe for drinking but people still continued to drink it. She noted an instance in which a young girl died from drinking the contaminated water. There are people who are not educated and cannot read, so they continue to haul water. She stressed that placing signs at contaminated areas does not solve the problem, and affirmed the need to educate their community since many of them still do not attend meetings. She asked the panel for other suggestions.
- Ms. Allison responded that it was great to hear feedback because concerns could be taken back and incorporated within the corresponding agencies. With regard to the livestock wells, there is a high level of nitrates. This is not surprising with livestock wells because nitrates come from the manure of the animals. There are simple water handling practices about which they inform the tribes. ATSDR staff members are really good about working with the CHRs and identifying data analysis reports, and the CHRs translate the information into the native language.
- Dr. Bailey stressed the importance of conducting these types of studies. She would have linked the deaths to uranium; therefore, it is very important for ATSDR conduct studies and to distribute this information to tribal leaders.
- CAPT Snesrud thanked NCEH, Ms. Allison, and the CDC ATSDR Tribal Advisory Committee. She noted that often there is not much opportunity to discuss environmental health, even though it is incredibly important to most tribal nations. Many land-based tribes, like Tohono O'odham, have raised environmental public health issues. She acknowledged that CDC welcomes and embraces more engagement. In addition, she noted that ATSDR has regional representatives that tribes can reach out to, and definitely need to take advantage of. She recommended contacting Tina Forrester, Director of the Division of Regional Operations.

- Dr. Bailey added CDC has made a commitment to be more engaged in relationships so that they can do more as an agency in assisting the needs of Indian country.
- Ms. Plaus from the Navajo Epi Center stated that most Tribal Epi Centers need access to experts. She stressed that it has been a real obstacle in that limited funding and resources are available, and therefore they do not have experts. She also cautioned ATSDR to beware of the limited resources when they do begin to become engaged with the tribes.
- Ms. Allison responded that some of the ways CDC / ATSDR could assist is through expanding their Tribal Colleges and Universities (TCUs) funding, and getting AI / ANs professionals out in the communities with public health and epidemiology degrees. In addition, she noted that they could look at their fellowships, and having placements in troubled communities, et cetera.

### Open Discussion

During this session, those present engaged in a general open discussion.

#### **Discussion Points**

- Mr. Crouch asked for more information regarding Epi Aids. In addition, he reaffirmed Ms. Allison's suggestion for more training professionals.
- Dr. Toomey stated that Epi Aids are an opportunity to bring in CDC scientists on a short-term basis for technical assistance where there are specific need issues that need to be addressed. For example, in instances where there are increases in cancer, CDC scientists conduct an investigation. The process simply involves identifying a specific health problem and submitting a request to CDC headquarters in Atlanta. They will identify the right people to perform the analyses.
- Dr. Bryan added that the TCAC could contact him at anytime, and he could also connect them with the appropriate person. He noted that the program was generally program-specific, even though it is run out of the Office of Workforce Development, but if the need is warranted, they would definitely work to make it happen.
- CAPT Snesrud stressed the importance of tribe's getting to know CDC, and what resources they can provide. She stressed that the committee should not hesitate to contact either her or Dr. Bryan with any questions and / or concerns related to the various tribal public health issues. Sometimes it is more important to develop a relationship with a national center because it is an issue that is particular to Indian country. The division has teams that currently work on related issues that transcend state and local communities adjacent to reservations that have similarities. The work and tools can be shared with Indian country. It is important to take the opportunity to reach out to CDC and ask for assistance.
- Ms. Reft indicated that she lost her brother in June at the age of 35. The cause of death is still to be determined, but his problems stemmed from an early age with molestation, which lead to alcoholism, and then an attempted suicide, which resulted in him becoming completely blind. More, he was diagnosed with rectal cancer. She stressed that his dying

affects many other people, and there are no mechanisms in place to discuss and deal with these types of issues. As a tribal leader, Ms. Reft said she feels like a failure because there are so many issues that she does not know how to address.

- Mr. Antone thanked Ms. Reft for her testimony, and said that he sincerely identified with her situation. He stressed that Ms. Reft was not a failure, and urged her to continue in her good efforts.

## Wrap-Up - Adjournment

### Summary of Formal Recommendations

- Bring SAMSHA and CDC leadership together to consider programming in Indian country with an agenda to increase investment in Suicide Prevention and other priority issues where there might be strengthened outcomes by collaborative work.
- Allow tribal organizations to have access to some of the expertise that CDC has as tribes develop methodologies to collect and analyze data, and develop statistical reports, it would be ideal to have an expert verify the work for flaws.
- Develop an annual report that will describe recommendations that have been made within the last two years, and the status of each.
- Schedule COTPER/DSLRL project officers to present at the next TCAC meeting to address CDC state guidance policies as they related to tribes. Require states that receive PHEP funding to make a formal report to share with TCAC and other tribal leaders (e.g., how many tribes did they serve, did tribes sign off on the plan, et cetera).
- Develop a strategic budget plan to determine what options are available for FY2011 and FY2012.
- Gain commitment of CDC/NCEH and ATSDR to assist Navajo with environmental and pollution issues.

### Discussion Points

- Dr. Bryan noted that CDC has had difficulties in the past in determining what constituted a formal recommendation versus an actionable item. He asked the committee to be really clear in defining recommendations, and if there are formal recommendations, identifying an actionable response to the recommendation, so that CDC can be more systematic in their response. He acknowledged that other issues appear in the notes that are important and require follow-up, and that there are other items that are clearer. He stressed the importance of gaining clarity before they end the meeting.
- Mr. Antone asked if formal motions would be adequate.

- Dr. Bryan replied that motions would be a clear way to identify formal recommendations. In the past, the notes contained lots of information that was raised in the discussion but were not necessarily formal recommendations from the TCAC to CDC. In addition, he stressed the importance of the recommendations being distinct, and not repetitious of ones made in the past. This was a plea from CDC to be more responsive to the TCAC.
- Mr. Antone stated that there has to be a quorum, but the committee could delineate their recommendations writing, and vote during a conference call. He expressed frustration that it had been two years since they have had a report, and stressed that this was another delay in moving forward. The committee will move forward with voting on recommendations via conference call so that they could have ammunition for their responses.

#### Motion

- Mr. Crouch agreed and stated that he believed the tracking list that was described by Mr. Atone, as well as Dr. Bryan's desire to have greater clarity on what to put on the tracking list, was very appropriate. He moved to accept all of the recommendations made thus far as formal recommendations for this group. Those present supported the recommendations thus far.
- CAPT Snesrud commented that this list of tribal recommendations, and the desire to have action and response from CDC, was appropriate. She noted that for many of the recommendations, CDC has reported specific work/response in progress for the past 2-4 years, and may just require status reports to the TCAC. She noted that TCAC recommendations are unique because they are an official advisory committee to CDC. The testimony that is heard from the tribal leaders at the consultation sessions is different as it may be specific to one tribe or several tribes. CDC is committed to these government-to-government consultations. CDC will respond to testimony heard and communicate how the testimony will influence CDC actions and response.
- Mr. Antone responded that their tribes send them to the TCAC meetings. Tribal leaders have to go back and give a report to inform their leaders of what was discussed. The cycle is repeated meeting after meeting. Consultations are different because tribal leaders bring in their position papers that are run through their legislative councils. But sooner or later the tribes are going to ask, "What are we doing?" "What is CDC doing?" The same information is being recycled. His area needs a written report. It validates what is discussed, as well as CDC presence in Indian country.
- Cynthia Manuel stressed the importance of these meetings. She commented that it was sad that everyone flies all the way here, and then people leave early. The conference calls never achieve a quorum. Sometimes they do not even get a chair to run the meetings. How can they even develop an agenda? They are there representing their people who cannot be there. She and her Nation are strongly committed and plan to fully participate. If she could not attend for the whole time, she would give up her space to someone else to attend. She agreed with Dr. Bryan because proper guidelines need to be put in place to make people accountable.
- Dr. Bailey said she hears a lot of frustration, and shared frustration in support of Mike and Ralph, which was why she and OCPHP put the triage system. Dr. Bailey has informed CDC senior leadership of the need for them and the National Centers and Offices they direct to be engaged and responsive to TCAC recommendations. OCPHO has put in place a process

that will help CDC executive leadership be more accountability in responding to recommendations. To move this along, as the Triage Committee reads the TCAC minutes, pull out recommendations and suggestions, send them to the appropriate center/office at CDC, and then within a short turnaround time following TCAC meeting, the TCAC hears from CDC about each recommendation. Was it accepted and if so what has occurred. If the recommendation was not accepted by CDC, why not? This is just a suggestion to help move the process along, and perhaps at the next TCAC meeting can be discussed more fully. The important element is that priority recommendation have to be identified and progress on them needs to be monitored to assure progress to an outcome is being achieved.

- Mr. Gilbert commented twice per year Alaska tribes meet with IHS to negotiate their funding agreements. Part of the negotiation is an Open Items List, which is a matrix of the things that the Alaska tribes have deemed important over the years, which require a response from IHS. Sometime things get checked off and sometimes they do not if they are long-term tasks. He thought the ultimate metric for this committee's success would be to see the VFC and non-VFC figures CDC has directed toward AI/AN programs increase.
- Dr. Bryan responded that they all have work to do with those figures. It took CDC a lot of time to get a process for engagement of tribal leadership with CDC senior leadership and development of a comprehensive AI/AN portfolio. The information for this AI/AN portfolio has now been collected for 5+ years so that trends can be analyzed. On the tribal side, tribal leaders need to review budget numbers (allocations) and CDC's investments in Indian country relative to the priorities of tribes, and then put them in a format that fits the director's goals and let CDC know where the existing or new funds need to be allocated. Internally, CDC needs to use the figures more effectively to pursue strategic planning across the agency.
- Mr. Valdo added that as TCAC members, they needed to make sure they have their FACA exemption, obtaining the proper documentation identifying them as the Designated Tribal Employee, so that when IGA provides more specific direction, TCAC is already prepared.

**Recommendations from Dr. Stephanie Bailey**  
**Chief, Office of Public Health Practices**

- Website development
- CDC / state guidelines for tribes
- Five-year funding, and the competitive nature of grants and set asides / budget strategy for FY2010
- Peer review panel make-up (to make sure it is more of a CDC strategy)
- Workforce trainings (public health expansion, competencies and trainings—use of the community to translate the science into practice)

Dr. Bailey added that the matrix that she has set up to receive the TCAC recommendations will allow CDC staff to review them within a certain time to determine what is doable, what is realistic within CDC, and what is not. If a recommendation is not realistic, CDC needs to get back to TCAC with that message. It is CDC's hope that following each TCAC meeting, a

tracking report can be given. Dr. Bailey stated that she would even attempt to have CDC IT staff incorporate the tracking system onto the website.

### **Discussion Points**

#### **Recommendation**

- Mr. Antone asked if the TCAC membership could, in the future, make their recommendations in writing so that a formal motion could be made to vote on the recommendations.
- Ms. Alcothley agreed and asked that the group have an outcome or result for each meeting so that they will know that their need has been met, and can respond back to our community. Also, she wanted to make sure that the problems that Navajo Nation has with receiving direct CDC funding to tribes are addressed. She wanted to know how they could make the change; if it is a policy issue, how can they approach that.

### **Confirm Date / Location for Next Meeting**

Mr. Antone, TCAC Co-Chair, solicited the group for suggestions for the dates either the last week in January or the second week in March for the next TCAC Meeting, scheduled to take place in Atlanta. The committee resolved to conduct the next TCAC Meeting the last week in January 2010. (January 26-27<sup>th</sup>, 2010)

### **Identify Priority Items for Next Meeting**

TCAC Co-Chairs, Chester Antone and Kathy Hughes, resolved to identify priority agenda items for the next meeting based on the August 2009 TCAC Meeting Minutes. Mr. Antone noted that priority items would be identified and forwarded to the committee via email for approval.

### **Discussion Points**

- Dr. Bryan stated that the format that was used for the current Consultation Session was different in that the sections were divided up into regional, CDC, and then national. He noted that the meeting in Atlanta would only address national issues, but wanted to know how the committee felt about maintaining a section of the agenda for CDC to share information similar to what was done at the August 2009 Consultation Session.
- Ms. Hughes responded that since tribes know so little of CDC, it was important to keep that section in the agenda. However, she stressed the need to allow more time for tribal leaders to speak, and for the committee to not dictate the subject areas for them to speak on.
- Dr. Bryan asked whether there should be less topic areas and more open mic time—perhaps a two-hour segment.
- Ms. Hughes replied that there should be more open mic time.

*With no further commentary, the meeting was adjourned at 5:26 PM.*

## 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