

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

7th Biannual Tribal Consultation Session

**Hosted by
Northwest Portland Area Indian Health Board**

August 24, 2011

Minutes of the Meeting

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Acronyms

AAIHB	Albuquerque Area Indian Health Board
AI/AN	American Indian / Alaska Native
ANTHC	Alaska Native Tribal Health Consortium
ARRA	American Recovery and Reinvestment Act
ASTHO	Association of State and Territorial Health Officials
BIA	Bureau of Indian Affairs
CCTI	Cambridge Communications & Training Institute
CDC	Centers for Disease Control and Prevention
CIOs	Centers, Institutes, and Offices
CLABSI	Central Line Associated Bloodstream Infections
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPPW	Communities Putting Prevention to Work
CRIHB	California Rural Indian Health Board
CTG	Community Transformation Grants
DASH	Division of Adolescent and School Health
DDT	Division of Diabetes Translation
DRH	Division of Reproductive Health
ECHPP	Enhance Comprehensive HIV Prevention Plan
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcement
GPRA	Government Performance Results Act
HAI	Healthcare-Associated Infections
HHS	Health and Human Services
IHS	Indian Health Service
ITCA	Inter Tribal Council of Arizona
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSM	Men Who Have Sex with Men
NCEH / ATSDR	National Center for Environmental Health / Agency for Toxic Substances and Disease Registry ATSDR
NASA	National Aeronautics and Space Administration
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCIPC	National Center for Injury Prevention and Control
NDW	National Data Warehouse
NHAS	National HIV / AIDS Strategy
NHSN	National Healthcare Safety Network
NHTSA	National Highway Traffic Safety Administration
NIH	National Institute of Health
NIHB	National Indian Health Board
NNAAPC	National Native American AIDS Prevention Center
NPAIHB	Northwest Portland Area Indian Health Board
OSTLTS	Office of State, Tribal, Local, and Territorial Support
PHEPR	Public Health Emergency Preparedness and Response
PPACA	Patient Protection Affordable Care Act
PRC	Prevention Research Center
PRT	Project Red Talon
PTSD	Post Traumatic Stress Disorder
PwP	Prevention with Positives
RCT	Randomized Controlled Trial
REACH	Racial and Ethnic Approaches to Community Health

RFP	Request for Proposal
RPMS	Resource and Patient Management System
RWJ	Robert Wood Johnson
SAMHSA	Substance Abuse and Mental Health Services Administration
SNP	Strategic National Stockpile
STAC	Secretary's Tribal Advisory Committee (HHS)
STAND	Students Together Against Negative Decisions
STIs	Sexually Transmitted Infections
TAC	Tribal Advisory Committee
TCAC	Tribal Consultation Advisory Committee
TIPCAP	Tribal Injury Prevention Cooperative Agreement Program
TMVIPP	Tribal Motor Vehicle Injury Prevention Program
US	United States
USET	United South and Eastern Tribes
USPSTF	US Preventative Services Task Force
WISQARS TM	Web-Based Injury Statistics Query and Reporting System
YRBS	Youth Risk Behavior Survey

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

**Consultation Session
Minutes of the Meeting
August 24, 2011**

Welcome / Opening Blessing / Introductions

**Chester Antone, Co-Chair
Councilman, Tohono O'odham Nation
Albuquerque Area Representative
Chairperson, Albuquerque Area Indian Health Board**

**Andrew Joseph, Jr.
Confederated Tribes of the Colville Reservation
NIHB Member at Large and Portland Area Representative
Chairperson, Northwest Portland Area Indian Health Board Chairperson
Tribal Council Member, Confederated Tribes of the Colville Reservation**

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

Mr. Antone called the meeting to order. He first called on Andy Joseph to offer the morning blessing and then requested that everyone introduce themselves. The participant roster is located at the end of this document.

Mr. Joseph first spoke the blessing in his own language, and then translated as follows: I ask the Creator for a blessing for each and every one of us, all of our people, for our families, our children, for the Mother Earth, and what we share this land with—the animals, the foods, the medicines, the water. For the ones who are our teachers, the elders and for the ones that doctor us, it might be our mind, our spirit, or our physical body, and we also ask for a special blessing for all the leaders, the ones here, the ones that might be traveling here, the ones that might be travelling to our other meetings as well as the state and federal government leaders. I would like to ask for a special blessing for our soldiers that might be in harm's way, that you give them the warrior spirit and bring them home safely so when they make it back here, hopefully their homes and everything are in better condition than what they left. For the ones that are mourning their lost loved ones, I ask the Creator to give them a special blessing to help them get through the tough times. I pray that we have a good meeting here, and that it will benefit all of the people in the future generations to come, thank you.

Dr. Holzman welcomed everyone, emphasizing that it had been a fantastic and productive two days thus far. The Tribal Advisory Committee (TAC) meeting was very informative and everyone learned a lot, although they had more work to do. He thought the site visit to Neah Bay was extraordinary and wonderful, and he thanked Brenda Neilson and others who worked on the logistics of that trip. These meetings are about learning, understanding, problem-solving, and generating new ideas. He thought they had done that and would continue to do so

throughout the Consultation Session. He stressed that there was a lot the rest of the US could learn from tribes.

During the site visit, Dr. Holzman said he felt like he was hearing firsthand some of the issues that were raised during the TAC meeting, and he highlighted some of those. For example, the work in Neah Bay to increase breastfeeding now exceeds the Healthy People 2020 recommendations. They selected an issue, addressed it, and moved the needle quickly from 2009 to 2011. He was also impressed to hear that the Makah Indians increased high school graduation to 100%, with 100% of graduates going onto higher education while continuing to honor and respect the history of their tribe. The Traditional Food Initiative's effect on local communities is a great success story in progress. There is potential to expand this great work beyond tribes to other communities. Everyone has different cultures and backgrounds, and can all learn a lot from revisiting historical traditions.

Dr. Holzman expressed his gratitude for being included in the TAC annual meetings and activities, and said he looked forward to a very productive third day. He asked everyone to remember to sign in, and indicated that they could check out during the first break and bring their luggage back to the meeting room.

Overview of CDC's Winnable Battles

Kathleen Ethier, PhD
Deputy Associate Director
Office of the Associate Director for Program
Office of the Director
Centers for Disease Control and Prevention

Dr. Ethier reported that about a year and a half ago, CDC identified some key areas in which they believed the agency could have a substantial impact. These key areas, known as Winnable Battles, include tobacco; healthcare-associated infections (HAI); teen pregnancy; nutrition, physical activity, obesity, and food safety; motor vehicle injuries; and HIV. Each of these areas is a leading cause of illness, injury, disability, or death, and/or represents enormous societal costs. Evidence-based, scalable interventions already exist and can be broadly implemented for each. CDC's efforts in these areas can make a difference, and results can be achieved within a short period of time. However, it will not be easy.

The agency receives a lot of questions regarding whether they are going to move resources into these areas and stop other efforts. It is important to remember that just because the Winnable Battles have been identified, this does not mean that the agency will stop working on other areas or that other issues are less important. Focusing for a period of time on some health issues in which substantial progress can be made quickly simply allows the agency to accelerate progress in those areas.

In almost all of the Winnable Battle health issues, American Indians / Alaska Natives (AI/AN) have disproportionate health needs. AI/AN adults and youth have the highest smoking prevalence of any group, 2/3 of AI/AN adults have unhealthy weight and more than half of AI/AN women are overweight, twice as many AI/ANs die in motor vehicle crashes as Whites, and AI/AN teens had the largest increase in birth rates from 2005-2007. While these numbers are clear and point in certain directions, they do not reflect the surrounding context. It is important

for the AI/AN community to help the agency understand the context in order to make a difference.

In terms of tobacco, there are some very clear strategies that are known to help reduce tobacco use and prevent exposure to second-hand smoke. These include increasing the price of tobacco products, promoting evidence-based policies, supporting 100% smoke-free environments, using aggressive earned and paid media, and Food and Drug Administration (FDA) regulations. CDC's work with Tribal communities in this area includes developing culturally appropriate interventions, working with the National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN), working with local governments to adopt tobacco policies and smoke-free work policies, and working with Montana Tribes.

There are also a number of strategies to improve food safety, nutrition and physical activity, and reduce obesity. These include changing the environment to promote healthy food and active living; addressing food procurement; improving foodborne illness detection, response and prevention; CDC's work with Tribal communities; Racial and Ethnic Approaches to Community Health (REACH) work on health disparities in American Indian communities; Centers of Excellence in the Elimination of Health Disparities work in Oklahoma and Colorado on American Indian cardiovascular disease (CVD) issues; the WISEWOMAN program; and Montana reservations' work on physical activity.

Strategies to reduce HAI include strengthening national surveillance through the National Healthcare Safety Network (NHSN); increasing implementation of evidence-based prevention guidelines in hospitals; ensuring federal and state policies to support transparency and accountability; sustaining HAI programs in states; and expanding prevention to non-hospital settings. CDC has a very particular role and shares responsibility for reducing HAI with a number of other federal agencies. CDC's role is focused on surveillance and reporting; therefore, the more the agency knows about the rates of HAI in organizations, hospitals, and other health care facilities are experiencing, the more that can be done about prevention. Strengthening national surveillance through the NHSN helps CDC and other federal agencies focus and target particular areas. There is a role for states, local governments, tribes, and territories to focus internally in their own healthcare settings. The more that is known about the safety of these settings, the more that can be done to ensure that prevention guidelines are being used. HAIs are almost entirely preventable, so by understanding where they are occurring and whether appropriate prevention techniques are being used, a major difference can be made.

Strategies to address motor vehicle safety include targeting 100% seat belt use, which can result in 4,000 fewer fatalities annually; reducing impaired driving, which can result in 8,000 fewer fatalities annually; supporting strong Graduated Drivers License (GDL) policies, which can result in 350,000 fewer non-fatal injuries and 175 fewer deaths annually; and collaborating with the transportation sector and other agencies to promote safety policies. In terms of CDC's work with Tribes, from 2004-2009 a pilot program was very effective at increasing seat belt and child safety seat use, and decreasing alcohol-impaired driving. The lessons learned from that program have been utilized to inform expansion of the program, and will be disseminated to tribes to allow them to adopt the evidenced-based strategies for their own communities.

Strategies to prevent HIV include increasing HIV testing to reach all Americans; ensuring access to proven interventions for negatives (e.g., comprehensive sex education and condom education), improving linkages to care; and promoting Prevention with Positives (PwP). CDC's work with Tribes in this area includes strong partnerships with the National Native American

AIDS Prevention Center (NNAAPC), the Indian Health Service National Sexually Transmitted Disease Program, and the HIV Prevention Education for Cherokee Nation.

There are a number of strategies to reduce teen pregnancy, including increasing access to reproductive health services, especially long-acting reversible contraceptives; reducing cost barriers to family planning services and contraceptives; expanding eligibility for Medicaid funded family planning services; addressing confidentiality; and working to change health professional and community norms. While teen pregnancy is not a leading cause of death, disability, or injury, it results in enormous social cost in terms of costs to society and in keeping families in a cycle of poverty. It can also prevent education for young mothers and their children. This cycle must be broken, but there is a great deal of controversy in this area. The last couple of years, CDC's focus has been to ensure that young people get the services they need when they need them. Medical eligibility contraception guidelines were published last November that show that for younger ages and women who have not yet had children, long acting, reversible contraception is safe, effective, and may be a better strategy for young women who want to put off child bearing for a period of time. The Department of Health and Human Services (HHS) recently released new preventive service guidelines for health insurance that are going to help dramatically with the costs associated with family planning services.

There have been a number of Winnable Battle accomplishments. Dr. Ethier emphasized the importance of sharing success stories and the importance of collecting these from the AI/AN community. The agency needs to share these stories with HHS and Congress as part of the larger picture. CDC's "Have You Heard" is a wonderful way of doing that, and there are on-going discussions within CDC about various ways that CDC can gather more stories to ensure that they are incorporated. While CDC is not trying to tell communities what their values should be, it is trying to share lessons learned from evidence-based efforts that can be used to try to make changes in AI/AN communities. There is a balance of keeping that conversation going so that AI/AN communities are involved in the Winnable Battles, without trying to impose federal values on these communities. This is a really difficult but important fine line to walk.

There have been a number of changes in the laws pertaining to tobacco and FDA regulations that have allowed for some changes in packaging and marketing. CDC is working on some regional mass media anti-tobacco campaigns. Tens of millions will see these ads, and many will quit. This is a precursor to a national campaign to be launched in late 2011 to early 2012. New cigarette pack warning labels will include the 1-800-QUITNOW national quitline number. CDC evidence supported this new FDA rule. Quitline calls more than doubled immediately following the FDA announcement. There have been some recent successes. For example, state tobacco taxes have been increased in Connecticut and Vermont. CDC published a *Morbidity and Mortality Weekly Report (MMWR)* on smoking in the movies. The total incidents of smoking in youth-rated movies decreased 71.6% from 2005 to 2010. Studios with written policies on depicting smoking observed a 92% to 99% drop in youth smoking in movies. Studios without formal, written policies had reductions of only 26% to 63% during the same period. There was also the release of the Community Transformation Grants (CTG) Funding Opportunity Announcement (FOA).

CDC has been surprised by the growth in its success with HAIs. At this point, more than 95% of United States (US) hospitals are enrolled in the NHSN. The agency set a one-year goal of 80%, which was quickly exceeded. They are now working to expand the types of facilities and types of infections that are reported to NHSN. A 58% decline has been achieved in central line associated bloodstream infections (CLABSI) in-hospital ICU patients. Currently, all 50 states have an HAI plan in place. It will be interesting to hear how that impacts tribes in each of those

states. There is now work being done in prevention of HAIs in outpatient facilities, such as long-term care facilities and dialysis facilities. CDC has released new, concise guidelines and checklists to help protect patients and educate clinicians about minimum expectations of safe care. These guidelines are for health care providers in outpatient care settings (e.g., endoscopy clinics, surgery centers, primary care offices, pain management clinics). These are important guidelines because people often acquire an HAI in the hospital and then bring their infections back to local healthcare facilities where they receive their on-going care. Thus, focusing on hospitals and outpatient care facilities is very important. There is also the Partnership for Patients Initiative, which is a public-private partnership among government, health care, insurers, and employers to improve the health and safety of patients in care by making hospital care safer, more reliable, and less costly. This initiative focuses not only on HAIs, but also on falls, deep vein thrombosis (DVT), and other issues that have the potential to affect the health and safety of patients in healthcare facilities. CDC is working to incorporate states, local governments, and tribes into this initiative.

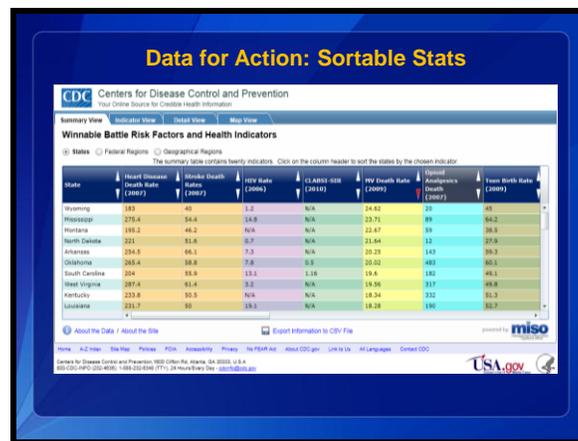
Motor vehicle crashes also represents an area in which CDC's work with tribes has been fruitful. Deaths from motor vehicle crashes have reached all-time low at 11.01 per 100,000 in 2009, which is a decrease of 10% from the previous year. Fact sheets are being developed for all 50 states on the cost burden of motor vehicle crashes. CDC supported the passage of GDL laws in Michigan and North Dakota, and released the "I Pledge" video campaign that is based on some work that the agency has done with parents to help them understand the importance of parents teaching and modeling good driving habits for their children. Motor vehicle crashes are a problem globally, so CDC has been participating in the Decade of Action for Road Safety initiative, which is a global initiative to cut the projected increase in road traffic fatalities by 2020 in half, saving 5 million lives.

There has been a great deal of excitement in terms of HIV around the idea of "Treatment is Prevention." Through the HPTN 052 Treatment is Prevention study, HIV-infected individuals initiating ARV reduce risk of HIV transmission to uninfected partners by 96%. CDC's new 5-year HIV FOA focuses on increasing HIV testing as a means for people to understand their status and take appropriate action. The expanded HIV Testing Initiative resulted in nearly 2.8 million HIV tests from 2007 through 2010. Of those tested, 1.1% tested positive and 62% of those were unaware of their infection.

Declines in teen birth rates resumed in 2008-2009, and birth rates among 15-19 year olds is now the lowest it has been in 70 years. State estimates of cost-savings from expanding Medicaid eligibility for family planning suggest that 19 states could expand Medicaid eligibility for family planning to each serve 10,000+ individuals, avert 1,500+ unintended pregnancies, and save \$2.3 million+ in state funding a year. Working with the Guttmacher Institute, CDC is in the process of developing some fact sheets for states about what they could do if they expanded Medicaid eligibility for family planning to include teens and a wider range of income eligibility to reduce teen pregnancy. California is the gold standard for states in terms of eligibility, so CDC is assessing their work to determine how other states can do the same. The idea of changing social norms for teen pregnancy is a very difficult concept. Social media can personalize and reinforce health messages, making them easier to tailor or target to particular audiences and to help change the national conversation. Social media also creates conversations. Information can be sent to audiences, and feedback can be obtained on the effectiveness and impact of the message.

CDC is also engaged in a number of broader efforts to support the Winnable Battles, and provide resources to states and other local communities to help them implement strategies at

that level. There is a new site within the CDC website called “Data for Action.” CDC generates a lot of data and many reports with a lot of data, but does not often put it in a format that makes it useable for people / communities to understand where they fit. Whether it is showing annual trends in the obesity epidemic or helping states know where to best invest their scarce resources, data are the foundation and driver of the decisions that are made. Within the Winnable Battles, CDC is in the process of providing data and analysis in many forms for states to use. One of these is a Pareto analysis, which demonstrates the Pareto principle (commonly known as the 80-20 rule) that the majority of the effects come from a small number of causes. In this case, 3 states carry 26% of the burden from motor vehicle related deaths. And only 10 states carry 50% of the burden. CDC is also working on what are called “sortable stats.” That is a website that provides an interactive data set comprised of 20 behavioral risk factors and health indicators associated with CDC’s Winnable Battles. This data set compiles state level data for the 50 states and DC, from various published CDC and federal sources, into a format that allows users to view, sort, and compare data associated with Winnable Battles by state, geographic region, or federal region as reflected in the following illustration:



CDC is also very much focused on trying to share best practices. The *Community Guide* is one way this is done. The agency would love to hear more from tribes about how to obtain the best practices from AI/AN communities, package them, and make them more widely available so that others can learn from them. Also important to the agency is advancing public health policy. The *National Prevention Strategy* was released in June 2011. This is an effort to determine what strategies could be more effective if all federal agencies worked together. CDC is also sponsoring State Policy Academies, which were in-state meetings in June 2011 among legislators and staff, executive branch leaders, and issues area experts in 6 states (Colorado, Massachusetts, Tennessee, Utah, West Virginia, and Wyoming) to develop goals related to the Winnable Battles and action plans for reaching those goals. There are plans to do this again with another set of states, and something similar could be done with tribes. The goal is to bring people together to focus on policy aspects of the Winnable Battles and how to create policy change.

Discussion Points

- Mr. Petherick noted that while the Winnable Battles program is reaching out to Indian Country, it is more of a CDC initiative. There are opportunities to discuss how tribes can be better engaged in the process such that it is a partnership.

- Dr. Ethier agreed. CDC has spent the last year or so “getting its own house in order” with respect to the Winnable Battles and has been trying to reach out to a variety of partners to do more of that work. While the agency views these Winnable Battles as areas in which they can make progress, they also recognize that these may not be others’ Winnable Battles. She encouraged everyone to use the Winnable Battles framework to determine areas in which they could make progress. There is nothing necessarily magical about these six areas. CDC spent time thinking about what the Winnable Battles might be and then harnessing the agency’s efforts around them. They often hear from states and others that alcohol or prescription drug use may be more of a problem than the six Winnable Battles in certain areas. They would love to hear about where AI/AN communities have made some progress, the community-based strategies that were used to make improvements, and how CDC can offer support.
- Mr. Joseph indicated that he sits on the Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory Committee, and that SAMHSA is allocating funding somewhat like block grants so that tribes do not have to compete to receive these funds. Perhaps CDC could do the same and the resources could be pooled. Efforts like the canoe journey and traditional foods initiatives offer opportunities to reach the younger generation, and a lot of disease prevention work could be done simultaneously. The country is struggling economically, and the states and tribes are in the same condition. He comes from a timber tribe. The housing market decline has devastated his tribe, with many of their people out of work. Everyone must “think outside of the box” about ways to make things better. It was mentioned that CDC could learn from some of the tribes. He brought his children up in a traditional way, and they have not had a lot of problems because of that. However, this is not true for every family. He recently heard a report from one of their IHS directors who reported that over 75% of the overall IHS budget was being used primarily for people who fell victim to alcohol and drugs by accident. The catastrophic emergencies that cost the government millions of dollars could be prevented. Perhaps spending more time engaging young people in cultural training would be helpful.
- Dr. Ethier replied that CDC often hears the desire to have more flexibility in its funding. While the agency is working to change how funding is allocated, funding comes to CDC in a variety of ways and some limits are placed on what they can do with funding. Still, they have heard some creative ideas about ways in which CDC can work across some of the silos to get more comprehensive work done. The structure of the way CDC’s money is received may not change, but perhaps the way in which they think about how its individual silos work together can change.
- Regarding HAIs, Mr. Antone pointed out that many tribal people go through IHS, but they are referred from IHS to outside hospitals that sometimes require distant travel. If someone gets an infection after surgery, it falls on the tribe to transport them back. He had an operation in November, followed by another one in February because there was an infection that occurred deep inside of him. The cost associated with that is unimaginable. His sister is still going through this after four infections. He emphasized the importance of AI/AN specific data about issues such as this, motor vehicle accidents, violence, et cetera. He also stressed the importance of partnerships with communities, because otherwise communities perceive some efforts as an imposition of values from the outside.
- Dr. Ethier admitted that HAIs was an area she knew the least about until she began talking to people in states and learned that this is an enormous problem. There does not seem to be a family who has not dealt with this in some way. It is surprisingly prevalent, but as CDC has elevated the problem, there have been major improvements.

- Dr. Holzman noted that when the six Winnable Battles were first announced, even states were frustrated. Having come from a state to the federal side, he has learned more about the concept. There are many good things about the Winnable Battles. First, these are areas for which there is an evidence base and for which a difference can be made quickly. Because of the evidence base, it is easier to convince policy makers to allocate funding to these issues. This is one way to help frame something to push it forward to other folks who may not know as much background on it.
- Mr. Petherick clarified that he had no question that the six Winnable Battles are important and tribes should be engaged in efforts to address them; however, we would like for CDC to take more of an active role in working with Indian Country to allow Indian Country to showcase how they can contribute to the Winnable Battles in their own ways. Tribes have a lot of capacity and a lot of ways that they can reach their populations that can be shared with CDC.
- Dr. Holzman said he agreed completely. The “Have You Heard” program is assessing efforts in the field. There needs to be at least one “Have You Heard” just about tribes, because there is a lot for the rest of the world to learn about from the great efforts in which tribes are engaged. He encouraged people to submit their stories so that they could be showcased in “Have You Heard.”
- Ms. Kaslow pointed out that the term “evidence-based” is somewhat intimidating. Oftentimes, the standard has to be one in which tribes can show outcomes that demonstrate that they have used interventions that are effective and measurable. Indian Country and California are very much aware of and sensitive to that, but the definition of “evidence-based” can be misaligned with the community values that CDC says they are advocating for. If the definition were more expansive and inclusive, just as what was shown by the Makah people during the site visit, it would be better. What they are doing in their communities is evidence-based in that it has been used for thousands of years and is highly effective. If it does not align with the standards that CDC has, then it is very difficult to demonstrate that what is being done is evidence-based. Tribes continue to struggle with having to apply standards that may or may not align with communities’ values, and being able to evaluate those standards becomes even more of a challenge.
- Dr. Bauer responded that CDC demands evidence-based activities when, in fact, there is not an evidence base. Nutrition is a key area in which the agency struggles. No one has turned around the obesity epidemic. CDC wants people to do things that have evidence behind them, but does not know what works because this has not been achieved anywhere across the US or across Indian Country. With the Traditional Foods Initiative, CDC knew that they wanted to change community norms around diet, but did not know what was going to work in states or counties across the US or in Indian Country. The way that funding opportunity worked was that the agency solicited ideas from individual communities about what they believed would work. There have been a number of successes with this program, which is another way to build the evidence base, and build it in a way that is specific to different communities that CDC wants to serve.
- Ms. Kaslow commended CDC on some of its programming in which there is quite a bit of flexibility. There is a tendency in some programs to resort to dogmatic approaches, so she is trying to look at things on a broader scale. The Traditional Foods Program demonstrates a broader, more inclusive approach.

- Dr. Ethier agreed with Dr. Bauer that this is an imperfect science that often does not have a lot of science behind it. This is the line with which CDC struggles quite a lot in terms of wanting to promote strategies that have some sense that they may work, but at the same time, it is imperfect and it does not always fit. This is another area in which the success stories they hear from tribes can help to form the evidence base and allow them to work more broadly.
- Mr. Secatero reported that in his area, he received \$200,000 for medical equipment from what they call "Big Navajo." While his shop received the check and has the equipment, IHS had to bid on that and it took 3 to 5 years. The only way he got it going was to go to Dr. Roubideaux. She made one call to his IHS people and had things rolling within a week. The point is that perhaps they could get those who are in charge of programs together so that they could get other things moving.

Moving Forward: Chronic Disease Work in AI/AN Communities

Ursula Bauer, PhD, MPH, Director

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) Centers for Disease Control and Prevention

Dr. Bauer thanked everyone for taking time from their families and communities to attend this meeting, to advise CDC, and for the honor of permitting her to discuss the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and some of its priorities and work in Indian Country.

Chronic diseases are a major problem across the US, across Indian Country, and around the world. Heart disease, cancer, diabetes, and obesity are causing tremendous suffering and burdening healthcare systems globally. Even though the burden is felt across the globe, the burden is not equitably distributed. There are areas in which the burden is much greater, and there is a special obligation to address those areas. NCCDPHP is focusing considerable energy on the current health status in the US. Much of the chronic disease burden is really the result of how our society is organized. Decisions that we have made or were imposed upon us in the past really constrain the choices and opportunities that we have today. One of the ways to address that is to revisit some of those historical decisions about how we as a society are buying our foods and feeding our families, what our relationship is to commercial tobacco, and how we are either supporting healthful behaviors or behaviors that are causing so much chronic disease in communities. There have been some very impressive successes in Indian Country, such as the Traditional Foods Program, Communities Putting Prevention to Work (CPPW), the Breast and Cervical Cancer Program, the Colorectal Cancer Program, and the Community Transformation Grants (CTF) for which there were 37 applications from Indian Country out of about 210 or so applications overall.

With regard to burden, chronic diseases account for 7 out of every 10 deaths in the US. Deaths from chronic diseases are burdening US citizens and community members, but the deaths do not tell the major part of the story. Considerable disability, suffering, and costs are associated with chronic diseases. The burden of chronic diseases is not being addressed commensurate with the magnitude of the problem in terms of the resources available, although the list of

chronic diseases (e.g., heart disease, cancer, stroke, diabetes, et cetera) is largely the same in terms of leading causes of death across communities. Some communities suffer more than others. Certainly, AI/AN have rates of some diseases, diabetes in particular, that are well above those of the US population overall. These rates reflect the differences in tobacco use, nutrition and physical inactivity, and obesity—the primary drivers of so many chronic diseases. As noted, commercial tobacco use; consuming foods that are high in sodium, added sugars, fats, et cetera, and limited opportunities for physical activity are, in some sense, determined by the way our society is organized. The challenge as communities is to redesign the landscape to support health instead of disease by putting in place permanent policies, practices, and physical structures that are going to encourage the healthful behaviors. Those could be smoke-free air laws, product placement policies that conceal tobacco products in convenience stores, more opportunities for cessation from tobacco use, parks, playgrounds, trails, physical activity built into the school day, and so forth.

There is growing awareness in communities across the US and among decision makers about chronic diseases being costly and debilitating, particularly given the media coverage. Three key behaviors (e.g., tobacco use, poor nutrition, and physical inactivity) are so malleable that a much better job can be done of promoting tobacco free lifestyles, promoting healthful nutrition, and promoting physical activity. The way society is organized can be changed so that it does not reinforce unhealthful behaviors, but instead supports healthy choices. The healthy choice must be made the easier, more convenient choice for US citizens. There has been significant success with this approach over the years. No one can imagine returning to a time in which cigarettes were advertised on television, when cars were built without seatbelts or airbags, and when the food supply was not regulated and inspected. In the future, 5 to 20 years from now, the next generation will not be able to imagine returning to a time when smoking was allowed in bars, restaurants, or workplaces, when restaurants and food service units did not provide calorie information on items being sold, when sodas and sugar drinks were sold in schools, et cetera. In a generation, sodas in schools will seem as out of place as cigarettes in schools seem now. There has been progress in changing the food supply as a whole, especially in terms of salt. Many people want to limit their salt consumption, but really do not have that choice because salt is in all of the foods that we buy, often in unexpected places like breakfast cereal and breads. A generation from now, we can hope that this will not be the case and people will be surprised that the breakfast cereal fed to children used to contain so much sodium.

Even as work is being done to transform communities by supporting healthful behaviors, tobacco free environments, changes in the food environment, improving quality of life, and so forth, those who already have a chronic condition must still be supported. Chronic conditions by definition are not cured and they do not go away. For many chronic conditions, such as obesity, there is really no evidence. For example, there is no evidence regarding how to reduce weight in people who already are obese and we do not have a good track record for this. There is also no cure for diabetes. Once someone has diabetes, the challenge is to manage the disease to avert complications and avoid the worst consequences. NCCDPHP has a role to support these efforts. Not surprisingly, this role is very similar to NCCDPHP's primary prevention work. It is known that across the weight spectrum from normal weight to obese, if someone is improving their nutrition and increasing their physical activity, regardless of whether their weight status is changing, their health status is improving and they are averting future complications. That is, someone is better off being physically active and overweight than being normal weight, but not being physically active. It is known that people with chronic conditions can dramatically improve their health status by engaging in these basic healthful behaviors (e.g., tobacco free, healthful nutrition, and increased physical activity). Diabetes is an area of particular concern because there is an evidenced-based, simple lifestyle intervention to avert or delay the onset of diabetes

among people with pre-diabetes (e.g., glucose imbalances) that puts them at great risk of becoming diabetic. Figuring out how to bring that intervention to scale across the country so that those who are at risk for diabetes have access to it represents a major challenge as well as an enormous opportunity.

Moving forward, NCCDPHP will increasingly be focusing on evidence-based, practice-based, and promising practices. The center is focused on scaling up interventions that have some promise to change the environment such that the healthful choice is the easy choice. CPPW is one example of this, and it is an area where NCCDPHP has learned a lot in the short lifetime of that program. This is only a 24-month project. Normally when combating chronic disease, NCCDPHP does not think in 24-month time intervals because it is often not possible to make changes and achieve health outcomes in that short timeframe. Instead, they think in terms of generations, because that is the timeframe it takes to develop chronic diseases and to change the landscape that supports them. With CPPW, NCCDPHP was challenged by Congress to invest \$650 million across the country to make changes in a 24-month period. Those 24 months will come to a close in March 2012, so the project is more than half way completed. There have been a number of successes in terms of changing policies and changing environments; however, there has not yet been the success of being able to say that the obesity epidemic has been turned around in a particular location, that diabetes prevalence has been reduced, or that smoking rates have decreased. There have been successes in getting smoke-free air laws in place; getting physical activity requirements in schools; and changing the nutrition standards for foods that are provided in schools, in government institutions, and so on.

Three tribal organizations competed successfully for CPPW funding. As with many of the grantees, they have achieved some success early on as well. The Cherokee Nation Health Services Group received over \$2 million, \$1 million for tobacco and \$1 million for obesity. They are working to implement a farm-to-school program where fresh farm produce is taken from the farmer to the school to improve the foods provided to their children. They are also working to improve physical education standards in schools, increase access to safe places for physical activity in the community, and develop tobacco product placement guidelines for Cherokee Nation businesses. They are also working to increase cessation services and availability of those services, and have had a number of successes to date including the adoption of a tobacco-free policy that goes into effect September 2011. In October 2011, contractors and vendors will be prohibited from smoking or using tobacco products in Cherokee Nation buildings, or on the grounds surrounding those facilities. That will affect thousands of contractors and vendors, and will protect many people from exposure to secondhand smoke. The Pueblo of Jemez received almost \$1 million for obesity prevention work, and is working to increase the availability of healthy foods and decrease the availability of less healthful foods, and to increase opportunities for physical activity. They plan to implement new policies that require all school menus to be approved by a nutritionist, and to increase the nutrition standards for foods that are available in schools to ensure that plenty of healthful fruits and vegetables are available. They also plan to implement youth-based initiatives to encourage children to get up and move, and to establish bike clubs and other physical activity initiatives to increase the number of minutes per day that youth and adults spend engaged in vigorous physical activity. The Great Lakes Inter Tribal Council received \$1 million for tobacco programs. They are implementing a number of initiatives to restrict access to tobacco for minors, support smoke-free air policies, and eliminate the use of rebates that reduce the price of tobacco products.

NCCDPHP used a number of the lessons learned from CPPW and REACH to design the CTG program. The CTG program is, in some sense, the successor to CPPW as it addresses many of the same key chronic disease risk factors (e.g., tobacco use, poor nutrition, physical

inactivity), but also expands to address other opportunities to improve health status related to chronic disease, especially in the clinical environment where there is a major focus on improving blood pressure control. CTG also aims to cement the community / clinical linkage so that the community is supporting particular patients with chronic conditions. The Diabetes Prevention Program is an example of that. The CTG initiatives are aligned with the National Prevention Strategy. In addition to the tobacco free living, active living, healthy eating, and clinical preventative services components, the CTG grants have the flexibility to address social and emotional wellness and healthy and safe physical environments. This can include motor vehicle issues, pedestrian issues, and physical activity. As mentioned, there were about 220 applications, 37 of which were from Indian Country. NCCDPHP has just over \$100 million to award by September 30, 2011. They hope to increase the number of grantees from Indian Country above the number that they were able to fund with CPPW. Unlike CPPW, the CTG program is a 5-year program, so there will be additional time to demonstrate impact.

During the February 2011 TAC meeting, NCCDPHP was asked to pursue the following four recommendations that CDC and NCCDPHP need to do a better job of:

- Understanding tribes and Alaska Native villages, and making sure that staff are culturally competent in delivering technical assistance to tribal communities;
- Disseminating promising and best practices so that information about what has worked in one community can be used to guide other communities;
- Providing technical assistance to tribes, particularly in the area of grant writing, to make sure that tribal communities are competitive when there are competitive funding opportunities; and
- Including tribes and Alaska Native villages in discussions in advance of developing FOAs to ensure that the programs being crafted with those dollars make sense for and meet the needs of the people in Indian Country.

To strengthen the distribution of best practices in Indian Country, NCCDPHP established an AI/AN workgroup and have tasked that group to develop a promising practices document that will identify a number of programs that have demonstrated a positive impact on health behaviors. The workgroup has begun the development of this document, and will package a “how to” guide that can be shared across Indian Country so that other communities can implement these programs as well. NCCDPHP hopes to share this document with the members during the next TAC meeting. The workgroup is also exploring how NCCDPHP can better educate its staff to engage and interact with tribes in a culturally sensitive way. There is an existing course for all CDC staff titled “Working Effectively with Tribal Governments.” NCCDPHP hopes to build on that curriculum to ensure that its staff members have the knowledge, tools, and support they need to provide Indian Country with the services needed to best implement the programs CDC is supporting. The workgroup is drafting a set of principles for working with tribal governments, which should be available to share with the TAC in February 2012 to ensure that it is on target.

There are some resources available to tribes regarding how to apply for federal funds, but NCCDPHP will work with OSTLTS and others in CDC to make sure that tribes are made aware of existing resources, and to fill in any gaps. The federal government is very large and there are many agencies with many different FOAs and mechanisms to apply. NCCDPHP would like to

develop an online training tool that will provide a “how to” for FOAs made available from NCCDPHP. They are also trying to do better across the board in terms of involving tribes in the development of FOAs. This recommendation has also come from state governments and national organizations. Often an FOA like CTG is published and people do not believe it speaks to them. They need to determine how to add in the time needed to hear from potential applicants before developing FOAs to ensure something is being crafted that makes sense to potential applicants.

NCCDPHP is trying to do a better job of harvesting success stories and sharing them. They have another document that they are pulling together distinct from the best practices document as another way to showcase all of the terrific work that is being done and the progress that is being made in order to demonstrate the value of the investment in Indian Country, as well as unmet needs that require additional investments. Success stories are particularly important as tools for decision makers. This collection of stories will also be made available to the TAC during the February 2012 meeting.

In conclusion, Dr. Bauer expressed her hope that she had demonstrated her commitment to take action based on what she learns during these consultations, and to report back any progress that has been made. She invited additional recommendations regarding how NCCDPHP can better meet the needs of Indian Country, so that they can take actions on those as well.

Discussion Points

- Mr. Secatero noted that during the 141 mile trip to Makah for the site visit, some of the elders said from their hearts that, “These people can help us. CDC can help us.” Montana has a problem with mining. The mining companies are washing out the gold from the mountain, and it is running right into where they have their gatherings. They are also asking for help. He requested that Dr. Bauer stress that this is important to him and his people are being affected. A uranium mine is opening back up next to the reservation. Because it is on private land rather than the reservation, the company can do what it wants. This will still affect those living on the reservation. What he heard from the people during the site visits was in his heart that day and it remained in his heart the next morning. It is difficult to help communities that are remote. In his community, they hardly have any water, so growing their own crops is a problem where he is from.
- Mr. Petherick expressed appreciation for Dr. Bauer’s presentation, and said he was glad Mr. Secatero raised the issues he did, because Cherokee Nation is one of the CPPW grantees. Going through the trainings and various activities for the grant has been somewhat of a challenge because a lot of the general activities for CPPW really do not resonate with Indian Country. Rather than talking about crosswalk signals and farm-to-school programs, they are having to deal with making sure that uranium mines are not impacting the water supply sources or even having water at all. Cherokee Nation’s activities will be a lot different from everyone else’s activities. That needs to be taken into consideration to make sure that what is taking place with CPPW can impact Indian Country as a whole. The tribal grantees can probably bring a lot of information regarding how to craft that message for the rest of Indian Country. There are many opportunities and he would be glad to help craft that message.

CDC's Winnable Battle: Motor Vehicle

CDC Tribal Injury Prevention Initiatives

CAPT Holly Billie, MPH

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U.S. Public Health Service

National Center for Injury Prevention and Control (NCIPC)

Centers for Disease Control and Prevention

CAPT Billie indicated that she is part of the Motor Vehicle Team in the National Center for Injury Prevention and Control (NCIPC). While people tend to think of this team as being a very large number of people working feverishly on motor vehicle injuries, the team is actually quite small compared to other programs at CDC. The Motor Vehicle Team is comprised of about 10 people, and she is the one person who works with tribes on that team. She has been at CDC for a couple of years. Before coming to CDC, she worked for IHS for about 18 years in various areas. The work she did with IHS focused on environmental issues and on injury prevention. At CDC, she works fulltime on injury prevention. The position she is in at CDC is unique. When she first arrived at CDC, she did not quite understand the history of this position. After having been there for a while, she realized that there was an agreement signed between IHS and CDC in the mid-80s. At that time IHS was Fulltime Equivalent (FTE) rich and budget poor and CDC was just the opposite, so NCIPC had a partnership with the IHS Injury Prevention Program. They decided to put this position at CDC. In some ways it is a joint position, but basically the FTE is provided by IHS and the salary is provided by CDC. In some ways, she feels like she belongs to both agencies, which is a great position to be in most of the time. Rather than just being an Injury Prevention Specialist, she thinks of herself more as a liaison between the tribes, other federal agencies working with tribes, and CDC. The last update CAPT Billie gave was in July 2010. At that time, she discussed some of the work her team is doing, and the broader more global work that NCIPC is doing. During this session, she focused strictly on some of the work being done with tribes.

The magnitude of the injury problem is significant. Injury is a leading cause of death for AI/AN as a whole, and is the leading cause of death for those 1 to 44 years of age. In terms of unintentional injuries (e.g., motor vehicle crash injuries, poisoning, burns, drowning, and falls), about 53% of injuries between the ages of 5 and 44 are due to motor vehicle crash injuries. Based on the latest data in NCIPC's Web-Based Injury Statistics Query and Reporting System (WISQARS™), the death rates per 100,000 population in states just for motor vehicle, for both sexes and all ages, range from quite low at 6.35 per 100,000 to very high at 87.19 per 100,000 in South Dakota. That is very significant, given that the age-adjusted rate for the US is 26.84.

The following table illustrates the primary funding streams for motor vehicle injury prevention in Indian Country in terms of the purpose of the funding, annual funding and number of tribes funded, focus, funding cycles, funding amounts, eligibility, and how CDC fits into the bigger picture of this effort:

MV Injury Prevention in Indian Country			
	IHS Injury Prevention Program	CDC National Center for Injury Prevention	BIA Indian Highway Safety Program
Purpose	Build capacity to address injuries	Implement effective & tailored MV strategies	Implement traffic safety projects and programs
Annual Funding/ # Tribes funded	\$2.7 Million 40 Tribes funded	\$674,000 8 Tribes Funded	\$4.5 Million 32 Tribes Funded
Focus	MV Injuries & fall prevention focus. Other injuries	MV only - SB, CSS and DUI prevention	MV only - LE based, alcohol, SB, traffic records
Funding Cycle	Multi-year, up to 5 years. Two types	Multi-year, up to 4 years	One year
Funding Amount	\$10-\$80K Drawdown	\$70K Drawdown	Up to \$500K Reimbursement
Eligibility	Fed recognized, 2500 min. pop	Fed recognized, 2500 min. pop	Fed recognized, any size tribe

Knowing that there are two other funding streams, CDC had to put a different spin on its efforts in order to obtain funding to address motor vehicle injuries. CDC decided to focus on determining whether strategies that have been shown to work in non-native communities, as printed in the *Community Guide*, could be tailored and implemented successfully in Indian Country. Due to the success of this pilot project and the need to expand it, NCIPC is funding an additional 8 tribes for the next 4 years. Notably, CDC's budget for this effort is quite small compared to IHS and BIA. IHS receives about \$2.7 million annually and is currently funding about 40 tribes. CDC receives about \$674,000 annually, of which \$118,000 is allocated to an external contractor with the University of North Carolina (UNC) to provide technical assistance to the tribes. Currently, CDC funds 8 tribes. BIA Indian Highway Safety receives \$4.5 million annually and is currently funding about 32 tribes. The funding cycles also vary somewhat. IHS and CDC offer multi-year funding for up to 5 years, while BIA offers annual funding. Tribes have to apply annually to BIA. CAPT Billie contacted BIA Indian Highway Safety and was told that they provide up to \$500,000 per tribe per year. However, this is done by reimbursement, meaning that if a tribe applies for \$500,000, they must have \$500,000 to spend and be able to wait to be reimbursed for it. This is a major limiting factor for many tribes, especially small ones. Over the last year and a half, CAPT Billie has made an effort to work with the program managers at IHS and BIA so that they can share information like this to help tribes understand the differences and similarities in the funding streams.

NCIPC has quite a few efforts underway that focus specifically on tribes, including the Tribal Motor Vehicle Injury Prevention Program (TMVIPP); the Tribal Motor Vehicle Best Practice Federal Partnership, which is a partnership between the National Highway Traffic Safety Administration (NHTSA), CDC, IHS, and BIA to address what really works in Indian Country; from different perspectives; webinars geared toward AI/AN audiences; fact sheets and other web resources geared toward AI/AN audiences; a policy improvement workshop; and an injury surveillance course with IHS.

The purpose of the TMVIPP is to implement tailored effective strategies in tribal communities to reduce alcohol impaired driving among high risk groups, increase child safety seat use among low use groups, and increase safety belt use among low use groups. Thinking about the comments made earlier regarding flexibility, because of the way this program was designed, for two of the strategies, there is very little flexibility (e.g., child safety seat and safety belt use). However, there is some flexibility as to how a tribe might address DUI. The inflexibility of the

funding lies in the fact that the justification CDC provided is that they wanted to determine whether evidence-based programs in non-native communities could be adapted to be successful in native communities. Tribes were asked to focus on effective strategies based on what CDC has published in the “Community Guide.” Through a cooperative agreement, four tribes were funded at \$70,000 per tribe. The four tribes are San Carlos Apache, White Mountain Apache, Tohono O’odham Nation, and Ho-Chunk Nation. They all had great program successes. They all increased seat belt use, and showed evidence that they were reducing injuries in their community. These tribes were also able to achieve a degree of sustainability. Once their funding ended, they were able to keep a portion of their programs going, or even all of their programs going, at least until they found additional funding.

The San Carlos Apache Tribe was included in the pilot phase. They were able to hire a coordinator and house that person in the police department. They were funded in the pilot phase from 2004 to 2009. Once their program ended, they were able to convince the Tribal Council to pick up that program as a whole. The next year, they were able to secure IHS Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) funding. This tribe has been recognized by a number of entities, such as the State of Arizona and the IHS Director, for their excellent program in reducing motor vehicle injuries. These are the kinds of results that NCIPC hopes to achieve when funding is provided to tribes to reduce motor vehicle injuries. The results the San Carlos Apache Tribe achieved are reflected in the following table:

Item	2004	2005	2006	2007	2008	2009	2010	% Change (2004-2010)
DUI arrests	308	385	411	391	468	533	359	+17%
Police-reported MVCs	338	276	247	297	240	235	240	-29%
Nighttime MVCs (6 PM – 5:59 AM)	146	102	98	121	107	107	91	-38%
MVCs with injuries/fatalities	104	87	83	101	72	79	73	-30%
Nighttime MVCs with injuries/fatalities	51	33	39	39	39	46	31	-39%
Drivers Restraint Use (%)	13	21	21	17	19	22	27	+108%

The San Carlos Apache Tribe also participated in a cost-benefit study from 2001-2008. That study found that medical care and productivity losses totaled more than \$57,000,000. Every dollar spent on motor vehicle injury prevention saved \$9.86 in total costs, so the total savings during that time period was \$2,700,000. This is a significant savings and for most policy makers, this is compelling [Piland NF, Berger LR, Naumann RM. Economic Costs of Motor Vehicle Crashes and Economic Benefits of Prevention for the San Carlos Apache Tribe. IHS Primary Care Provider December 2010, pages 272-277]. NCIPC talks about the successes in the program as often as possible. This information is included in NCIPC’s website. Though NCIPC includes a synopsis of its work, the tribes are writing the stories themselves. The first one is in the clearance process currently. It is a success story called “Ho-Chunk Nation Launches a Road Safety Program” that was written by Rob Voss of the Ho-Chunk tribe. Once

cleared, it will be available for distribution. The NCIPC Native American Road Safety page has information about the successes of the tribes NCIPC has worked with in this program.

This new cycle of the TMVIPP is underway. During CAPT Billie's July 2010 update, NCIPC was in the process of accepting applications for this funding. The purpose is to implement tailored, effective strategies by reducing alcohol impaired driving and by increasing seat belts and car seat use. There were many lessons learned from the pilot group, and these have been applied to this second cycle of funding. NCIPC developed a manual for tribes based on the lessons learned, which really helped to improve a number of aspects of the program. One of the lessons learned was that during the previous funding phase, each tribe was responsible for hiring their own evaluator to help them with technical assistance, data collection, and data analysis. With this cycle of funding, NCIPC has hired one external evaluator (UNC) to help all tribes. The newly funded tribes under TMVIPP include the following:

- Caddo Nation
- California Rural Indian Health Board
- Colorado River Indian Tribes
- Hopi Tribe
- Oglala Sioux
- Rosebud Sioux
- Sisseton-Wahpeton Oyate
- Southeast Alaska Regional Health Consortium

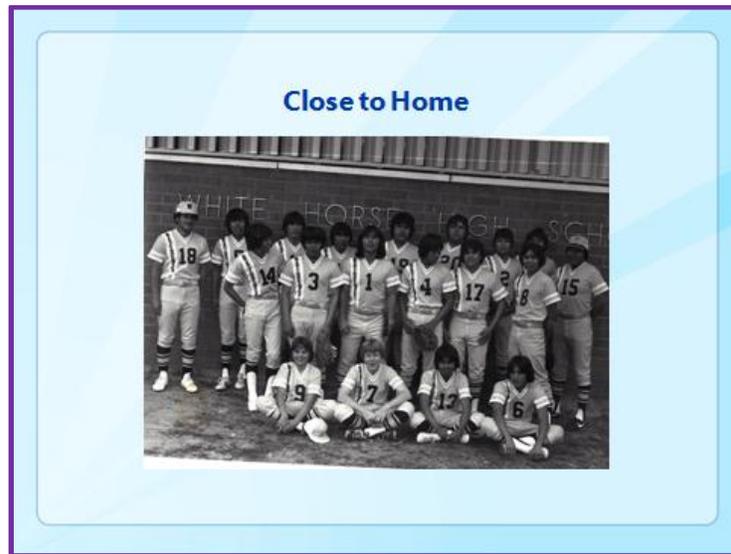
After they were awarded, NCIPC was able to secure additional funding for tribes that were interested in focusing on teens and teen drivers. They were able to apply for up to an additional \$32,000 to focus on teens and restraint use, DUI prevention, and GDL programs.

Another tribal initiative was the Tribal Best Practice Meetings, the purpose of which was to identify critical components for successful motor vehicle programs. Participants included a number of federal agencies (NHTSA, BIA, IHS, CDC) and a number of tribes, including Menominee Tribe of Wisconsin, Sisseton Wahpeton-Oyate, San Carlos Apache, Navajo Nation, Ho-Chunk Nation, and Oglala Sioux. This was a way of acquiring advanced input before the next RFPs are published for these three agencies. They were able to learn quite a bit through this process. For example, one critical component is multi-year funding. Tribes also felt strongly that more than \$70,000 to \$80,000 is needed to run a successful program, which will certainly be considered in the next cycle of RFAs. There is a report pending from the two meetings that CAPT Billie said she would be happy to share with the TAC.

NCIPC is also developing CDC webinars specifically targeted to those who work with tribes. The two completed thus far are on GDL and the WISQARS mapping feature to show how to pull just the Native American data out of the WISQARS program. Upcoming webinars will address the topics of ignition interlocks, suicide prevention, and older adult fall prevention. In partnership with IHS, NCIPC is developing an injury surveillance course. Data and data collection are very important, but can sometimes be a challenge in Indian Country. This course is designed to help those who are trying to obtain this type of information. CDC is providing funding for the development of the course that will be administered through IHS. This will become one of the courses offered in IHS's cadre of short injury prevention courses currently being offered. CDC is also developing fact sheets and web resources that should be on the NCIPC website in November 2011. They have also received funding for a Tribal Policy Improvement Workshop, the purpose of which is to assist tribes in their efforts to strengthen

traffic safety laws (e.g., primary seatbelt laws, child restraint laws, and .08 DUI laws). This is another joint effort between BIA, IHS, and CDC. Tribes who have successfully passed laws will present lessons learned. The workshop is open to all tribes and all tribes are invited to come. This workshop will be convened November 15-16, 2011 in Albuquerque, New Mexico.

CAPT Billie emphasized that motor vehicle crashes are the number one killer of Indian people. While statistics are necessary to paint the picture, the following photograph touches on a more personal note:



After she had been in injury prevention for a while, she found this old photo of the baseball team from her high school that reminded her of these issues being close to home. In following up on what happened to the people in the photograph, she found that some went on to be quite successful. One is an engineer who works with a large contracting firm that has a contract with the National Aeronautics and Space Administration (NASA), one is a physical therapist, and one is a urologist and surgeon. However, 5 members of that team died in motor vehicle crashes at different times, while they were in high school or shortly after graduation. That is nearly one-third of this baseball team. One of them was her relative and one was her brother's best friend. Unfortunately, these stories are common. It is such a major problem that most people in Indian Country know someone or have had someone in their family die in a crash. For a lot of tribal communities, this is still the scenario and unfortunately is normal. When she talks about motor vehicle injuries being the number one killer of Indian people under the age of 44, it is amazing to her that no one is outraged about this.

In terms of what can be done about motor vehicle injury prevention, NCIPC can continue to advocate for motor vehicle injury prevention funds on behalf of tribes. This is really about teamwork, and CAPT Billie tries to approach it that way when working with a tribe. All of the hard work that they do in the field makes it easier for her to advocate within CDC. The better the work she does within the agency, the better work tribes in the field can do. For IHS budget negotiation rankings, each area determines the top 10 health issues for their region. When she worked at IHS and with the tribes, this was one way they could put the health issues in the forefront. Injury prevention should be a priority in the IHS budget rankings. Another way to help

is through support of local programs by funded by IHS, BIA, CDC, states, and other sources and support of strong traffic laws (e.g., primary seat belt laws, .08 DUI laws, child restraint laws).

In conclusion, CAPT Billie said she really appreciated all of the support that she has received from Dr. Frieden. She has always been pleased when he talks about the motor vehicle Winnable Battle, and he usually mentions the tribes and the tribal program. She invited questions and comments during this session, or by phone or email if anyone thought of something after the meeting.

Discussion Points

- Ms. Sabattus noted that the 2500 minimum population requirement eliminates 22 of the 27 tribes within the Nashville area. She wondered what could be done to change the requirement.
- CAPT Billie responded that the agencies have discussed this. When these decisions were made, at least from CDC's side, there were arguments from both sides about using that population limit. CDC is attempting to achieve statistically significant findings, because their overall goal in the end is to develop a best practice manual that all tribes can hopefully tap into. Having worked a lot on the tribal side, this was a frustration for her when she worked with tribes. IHS's approach was to have a separate pot of funds for tribes that do not meet the population limit. That certainly will be considered if this funding continues for another cycle. The current funding cycle for CDC for the 8 funded tribes ends in 2014. She emphasized that it is a hard sell to acquire more motor vehicle funding from the CDC side, given that the BIA is specifically funded and tasked with addressing motor vehicle injuries in Indian Country. NHTSA treats that office like a state office. Each state has a Highway Safety Office that caters to the population in that state. The BIA Indian Highway Safety Office functions pretty much the same way in that they receive funding from NHTSA and are supposed to distribute those funds through proposals from tribes.
- Ms. Sabattus stressed that this did not negate the fact that CDC completely wiped out her area for CDC funding.
- Mr. Antone pointed out that Ms. Sabattus's area is not the only one for which this creates a barrier to entry into this program. This problem occurs in many areas. This is a loss for these communities, as well as a loss of important tribal data specific to communities of that size. When assessing best practices, it cannot be assumed that a best practice for a tribe over a certain population rate would be identical to a practical application or a best practice to a tribe that is below a certain population rate. Smaller tribes have very different circumstances and issues that have to be addressed. To support Ms. Sabattus's comments, while they understand and heard what CAPT Billie was saying in terms of sharing the frustration, the question remains about what can be done to change this. The consultation process is designed to bring forward very concrete concerns and to find very concrete answers. He inquired as to whether BIA and IHS would be in attendance at the November 15-16, 2011 meeting in Albuquerque.
- CAPT Billie responded that this is a joint project between BIA, IHS, and CDC. All tribes are also invited to attend.
- Ms. Nielson concurred with the suggestion for CAPT Billie to take a message back her leaders about minimum populations. On the site visit the previous day, they traveled on

winding one- and two-lane roads along the coast that some of the coastal tribes have to drive every day. Perhaps if her leaders had been on that trip, they would consider funding some of the smaller tribes. It would not even have to be \$70,000. Even a few thousand dollars would help some of the smaller tribes purchase infant seats and car seats for their toddlers. She said she understood that CAPT Billie was just the messenger at this point, but it would be beneficial for NCIPC leadership to attend these very important visits to rural reservations.

- Mr. Joseph also spoke in favor of some of the smaller tribes. The Portland area has some small tribes in rural areas. His tribe is large, but they have a lot of highway and three mountain passes that sometimes have four feet of snow. It is really dangerous, and it is hard enough for the county, the state, or the BIA roads program to keep them maintained and open. The conditions are harsh. He has traveled to Makah, and the road is winding with many hills. The roads are dangerous enough, but when they freeze they are even more treacherous. As he mentioned earlier, when he worked with the SAMHSA Advisory Group, they would mention the 15 tribal grantees, but he wondered about the 530 plus tribes who were not benefitting from the funds the federal government is spending. There were only 4 tribal grantees for CDC, none of which help anyone in the Northwest. He suggested that CDC review how SAMHSA is administering their new grant that is non-competitive, with every tribe receiving some funding. Overall, the cost savings to the federal government could be substantial if prevention is occurring because of this money. If the point of PPACA is to try to save the overall government a lot of funds on addressing tragic illnesses or accidents, to him this is money well spent. Tribes will put the funding to good use. In his community, they have a drive by flu shot program that takes place around their celebration grounds. They are also given information. This is an effort toward prevention, and people do not even have to get out of their cars, the vaccines and information come right to them.
- Dr. Ethier requested further information about the funding for the 8 tribes and whether it had a particular intent behind it. The folks who designed the program seem to be looking at it as a research project, and are trying to get an answer to a particular question out of it that does not seem to fit the needs of small tribal communities, particularly very rural tribal communities. She heard comments about small amounts of money to buy car seats, the narrowness of roads, and the weather issues and was wondering if they could have some greater appreciation for some of the very particular barriers that small communities face and whether there are other ways CDC can help them aside from this particular FOA.
- Mr. Petherick thought working through the area Inter-tribal Health Boards or the Tribal Epidemiology Centers would be excellent. In Oklahoma, the Tribal Epidemiology Center has trained people to put in car seats and train others.
- CAPT Billie noted that these issues were raised during the joint meeting with BIA and HIS. They wanted to make sure they are getting the word out about the various types of funding, all of which are structured in a slightly different way with varied amounts and eligibility criteria. It is very difficult to have a program that meets every single need of every tribe, but if they get the word out about these different types of funding, at least information would be disseminated to the tribes that there are other pots of money to address motor vehicle injuries. For small tribes, at least for this cycle of funding, the BIA funding is available.
- Ms. McKinley supported all of the statements that had been made, and pointed out that throughout the three days of these meetings, one of the questions that was raised previously was raised again: How can CDC successfully engage with tribes? When barriers

such population limits are raised, it will be very difficult to get tribes to engage. This is perceived as a barrier to prevent tribes from accessing funding. The other statement that was made was a request to have tribes support motor vehicle accident funding in the IHS budget meetings. If there is a barrier placed before tribes, they are not going to support that knowing that there is no way if they are a smaller tribe that they are going to be awarded that funding. They are not going to pay attention, and they will put that aside. She also heard another statement that this funding is based on answering a research question, and she wondered whether tribes were aware of that. She emphasized that when tribes hear the word “research,” red flags go up due to tribes facing a history of barriers. If they perceive more barriers, they are not going to participate. There should not be so many rules connected to the availability of funding or tribes will not buy-in.

- Dr. Ethier clarified that she misspoke and should not have used the word “research.” She was trying to liken the funding for gathering best practices to research that is intended to collect a particular set of information. She stressed that she did not mean to suggest that this was a research project. Instead, she was trying to suggest that it was more narrowly focused and, therefore, perhaps there were some other ways of trying to meet the needs of smaller tribes than just through this funding.
- Ms. Kaslow noted that they heard something very interesting from the Makah community during the site visit that may be fitting in this particular situation. One of the elders spoke about their community needs and described how, within her family, it would be interesting to see a profile of health risks that have been in their family inter-generationally and how those health risks might be mitigated or impacting the next generation. This seems like an important piece of missing information rather than just saying a community is eligible because they have a certain number of people. That obscures the relative risk of any given community. Instead of having the condition of roads put into the matrix, the level of rurality, the potential risk levels of substance abuse, the level of cars or vehicles in the area—all of the things that might contribute to a particular community experiencing a certain level of vehicle injuries should be included. California is fortunate to have one of its tribes funded by one of these grants, but that leaves 110 other tribes that are not even on the list. It is a challenge to think that the only way they can make the funding fit the tribe is by the number of the population. A tribe of 2400 individuals who are more rural may have worse road conditions, a higher level of teen drivers, or any number of risk factors. It is possible that overall impact will not be understood because only certain types of communities are funded. It seems that data are gathered at the county or even smaller levels, but it is aggregated for edification at the state level, which seems to obscure the needs on a more localized level.
- Ms. Sabattus asked whether the eligibility criteria were mandated by Congressional language or CDC determined this.
- CAPT Billie responded that her understanding was that the number was established by the IHS program. The first RFA for the pilot program was put in place before she came on board. From what she understood, her predecessor looked to IHS to find out what their lessons learned were from their first group of funding, and they had put a 2500 cap on their funding for various reasons. There was quite a bit about the population criterion written in the RFP to explain the 2500 population requirement. This was not in the Congressional language for the funding.
- After being there for three days, it was unclear to Dr. Holzman why the TAC meeting is conducted before the Consultation Session. On Monday, they discussed subcommittee

groups and talked about issues they wanted to be raised with the STAC. Some interesting issues had arisen during this session that may have been addressed differently on Monday if they had been raised earlier. The ultimate goal is to decrease morbidity and mortality in Indian Country, and in this case, that would be from motor vehicle crashes.

- Mr. Antone responded that some items keep coming up that have not been resolved, and that is why they came up as something to address with STAC.

CDC's Winnable Battle: Healthcare-Associated Infections

**CDR Arjun Srinivasan, MD, FSHEA
United States Public Health Service (USPHS)
Associate Director for HAI Prevention Programs Medical Director
Get Smart for Healthcare
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Dr. Srinivasan pointed out that the topic of HAI was relatively new to the public health world, not because it is a new problem, but because of the new recognition that HAIs are a significant public health issue. It is known that probably millions of these infections occur in the US healthcare system every year, and that they contribute substantially to lost productivity and even death for patients. In the last decade, it has been determined that many of these infections can be prevented through relatively simple and straightforward measures that already exist. The major change in the field of HAI in the last several years has come from the increasing focus by a large number of groups (e.g., consumer organizations, healthcare professionals, legislators) on ensuring that everything possible is being done to prevent HAIs. Significant progress has been made, and there have been a number of wonderful examples of large reductions in HAIs at individual facilities and at state, regional, and national levels. It is a particularly exciting time in this field.

CDC engages in a number of activities to promote and assist with the work being done in HAIs. For example, the agency provides a mechanism for healthcare facilities to track HAIs that is called the NHSN. This is a web-based system that is free to anyone who wishes to enroll. This system allows healthcare facilities to report information into the system, and then use that information to assess the effectiveness of their own efforts and compare their efforts to other types of healthcare facilities that are similar. This system is being used by over 4,000 hospitals in the country. It has been very helpful for people enrolled in the tracking system, and is a tool that many more places should avail themselves of. CDC also works with healthcare facilities, collaborative organizations, and health departments to establish and help run prevention collaboratives. These are groups of healthcare facilities that work together to prevent one or several types of HAIs. Because CDC was fortunate enough to receive funds through PPACA, they have been working with all of the state health departments to leverage resources and work on these types of prevention projects.

In conclusion, Dr. Srinivasan invited everyone to offer input regarding how CDC could learn more about this issue in tribal health facilities and what support the agency might offer with on-going or future efforts.

Discussion Points

- Dr. Holzman pointed out that the TAC members are the leaders of their communities, so getting information to them is very important. The next step is also getting information to the individuals working on the front lines about issues such as HAIs. HAIs represent a universal issue that needs to be discussed from the smallest hospitals to some of the larger tertiary centers.
- Mr. Antone reported that in March 2011 at the HHS Budget Formulation and Policy Consultation, he asked Drs. Roubideaux and Monroe to work together to address this issue because a lot of funds are spent referring tribal people off of the reservation clinics to hospitals or other specialty facilities. Their self-service unit does not have the capability for surgery or other major types of interventions. They refer patients to Tucson either to St. Mary's, Tucson Medical Center, Northwest Hospital, or St. Joseph's. People acquire infections in these facilities and bring them back to the IHS facilities where they receive wound care. Sometimes they become re-infected and require additional surgery. He wondered whether Dr. Srinivasan has had any contact with IHS in this regard.
- Dr. Srinivasan responded that he has had contact with IHS about this issue. He was contacted that day by a lawyer from IHS at the behest of others at IHS who are evaluating the options for IHS facilities to participate in and obtain data from NHSN. He indicated that he could connect anyone interested with that group at IHS.
- Mr. Antone indicated that he would appreciate having that connection. He reviewed the State of Arizona's plan, which does not really address aftercare. When patients return back to Indian Country, it falls on HIS, but they are not included in that report.
- Ms. Hearod indicated that she was representing Tribal Self-Governance Advisory Committee (TSGAC), and is from the Choctaw Nation of Oklahoma. She talked with her staff who said the State of Oklahoma plan includes only hospitals that have ICUs. Although the only data that they are collecting are from facilities that have ICUs, many tribal facilities that have hospitals do not have ICUs. Therefore, they are missing a lot of data from the tribal facilities.
- Dr. Srinivasan replied that a lot of the focus for facilities reporting information has been in the ICU setting because that is where the highest frequency of infection occurs. CDC agrees that they are missing important data, and is actively promoting the monitoring of these infections outside of ICUs in other settings where most of the patients are. Though the frequency of the infections may be less, the number of infections is probably much more because that is where most people are. CDC has observed that monitoring activities are increasingly being expanded outside of ICUs. This is occurring slowly because it requires additional resources, but there is growth in this area.

CDC's Winnable Batter: HIV

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Centers for Disease Control and Prevention

Ms. Margolis began by saying that this is a really exciting time in HIV prevention. The National HIV / AIDS Strategy (NHAS) was published in July 2011 and marks the first time the nation has

ever had a national AIDS strategy that includes an implementation plan and calls on agencies to engage in various efforts to achieve the goals set forth in the NHAS. The NHAS goals are to reduce the number of new infections by increasing the number of people who know their HIV status, linking people into care, reducing health disparities, and increasing collaboration across agencies. One of the items in the strategy calls for a tribal consultation to obtain input into how scalable interventions can be implemented that will have the biggest impact on priority populations of persons at risk for HIV. She invited input because they will be designing that consultation later in 2011. A call has already been scheduled with IHS staff to begin discussing the next steps toward arranging that tribal consultation.

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) recently published HIV incidence estimates from 2006 to 2009 which showed that the number of HIV infections in the US have remained relatively stable at 50,000 new infections per year, which is still not acceptable. There are very severe racial disparities in the data. NCHHSTP reported that basically the numbers had been level in all population groups except for young black men who have sex with men (MSM) for whom the increase over that time was 46%, and the number of infections is still about 60% of the epidemic. In Indian Country, the numbers are really small, so it is difficult to know whether they are accurate. There are still issues in Indian Country around HIV testing and people knowing their status. In terms of co-morbidities, there are high STD rates and high Hepatitis C rates, so there are concerns about making sure everyone in Indian Country knows their status, especially those who are at high risk for HIV infection.

Ms. Deravello said that since they were in the Portland area, she wanted to take the opportunity to brag about some of the great HIV / STD projects underway there. She thanked Joe Finkbonner, the Director of NPAIHB, for his leadership in making sure that Project Red Talon (PRT) out of the NPAIHB has continued successes and continues to identify wonderful staff to take on their great new projects. STD and HIV prevention programs in Native communities are focused on youth, youth behavior, and healthy decision making. It is important for youth to have better abilities to make good decisions for their health. Some of the projects focus on STDs, HIV, teen pregnancy, and some are comprehensive. However, they are all working toward the same end goal. PRT has developed a second version of its tribal leader advocacy kit. This kit includes a PowerPoint presentation, handouts, and background information so that someone who wants to present to their tribal council on the impact of STDs and why it is important to support STD prevention and control would have the tools needed to make that presentation. This has been used a lot by NPAIHB, and is available on their website for anyone to download.

Another exciting project is from the Shoshone Bannock Tribe in Fort Hall, Idaho called "Healthy and Empowered Youth." This is a school-based health curriculum that is loosely based on another curriculum called Native STAND (Students Together Against Negative Decisions). The Shoshone Bannock Tribe modified that curriculum to make it their own. They added a film-based component so the youth who go through the program are also learning how to make videos and digital storytelling. The school board has made this class part of the requirement for 7th and 8th graders. They go through this healthy decision making curriculum, and are using films to help tell their stories. The Project Red Talon website has a Facebook page about this project, and YouTube has the videos the youth have made. One of the films, "Healthy and Empowered Youth" made it to the Film Festival during Indian Market in Santa Fe. Native STAND was developed by a group comprised of representatives from IHS, CDC, National Coalition of STD Directors, Mercer University School of Medicine in Georgia, and Native youth and elders. Native STAND was pilot tested in Bureau of Indian Education Residential Schools last year. An evaluation was conducted over the summer, and the final curriculum will soon be posted online.

for anyone to use. It will have its own website at www.nativestand.com where some items have already been posted. There will be facilitator and peer manuals, as well as a resource guide. The entire program is 30 sessions that are an hour and a half each, which can be implemented differently in various settings. Some people may decide to pick and choose sessions, some may complete one session per week, some may implement it in an afterschool program, and some may implement it as a summer camp.

PRT has also developed a social media campaign called "We Are Native." This is a website that includes a texting component. Someone can text a certain code to a certain number and will receive healthy messages, quizzes of the day, and other items to engage them. This includes a Facebook page, Twitter, and a website. Native youth, just like any youth, are very technologically savvy and very connected. These are specific tools and interventions that were developed for them, but that are very cutting edge. PRT is also working on an adaptation of a project called "It's Your Game." This project is one of the effective programs that CDC has blessed as being effective in promoting healthy sexual behavior in youth. It is an online, computer-based, educational tool. Though it was developed for non-native audiences, CDC's Division of Reproductive Health (DRH) is funding the University of Houston's Prevention Research Center (PRC) to work with PRT, Alaska Native Tribal Health Consortium (ANTHC), and the Inter-Tribal Council of Arizona (ITCA) to adapt the "It's Your Game" health curriculum for Native youth. This is well-funded and it is going to be a well-studied and well-evaluated adaptation.

Another intervention being adapted for Native youth is "VOICES/VOCES," which is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The point of this program is to minimize the barriers that come with people feeling very uncomfortable about condom use in order to try to promote healthier, safer sex. The adaptation is called "Native Voices." This, too, is going to be a well-funded, well-evaluated intervention for Native youth.

NCHHSTP is working on a project with ANTHC that is based on an intervention from Johns Hopkins that is an internet-based, self-collected specimen project. Someone who thinks they have an STD, who is too nervous or shy to go to the clinic, can order an anonymous kit online that will be mailed to their house in a brown paper-wrapped box with no label. This has been very well-accepted by people, even more than having a provider collect the specimen. Individuals collect their own specimens, mail them back, Johns Hopkins runs the tests, and the results are communicated to the Tribal STD Program, which contacts individuals to ensure that they and their partners are treated. This project is open to any Alaskan, and there is no requirement to be an Alaskan Native even though the project is being sponsored by ANTHC. It took three years to get all of the approvals in place. Orders recently started being accepted. In the first week, there were approximately 100 orders. They did not know whether this was just because people were curious, or if it is the nurses wanting to know if it is going to work before they promote it. They are waiting to see how many test kits are returned. In Alaska Native villages, an intervention like this is really important because there may be 50 to 100 people and only one provider who is someone's auntie down at the corner. Thus, people are not going to get an STD test. They will wait until they go to a hub or Anchorage, but by that time they have continued spreading the STD to others. NCHHSTP is trying to encourage STD and HIV screening in Indian Country, especially given the numbers and that they do not have a very good picture of what is occurring. The only way to get that picture is for more people to be screened. The recommendation from CDC is that every person between 13 and 64 years old should be screened at least once in their lifetime and more if they are at increased risk. There is also a recommendation for pregnant women to be screened. IHS and CDC are working on

an indicator project to help IHS, tribal, and urban facilities assess their data to determine where the gaps are in screening and how these gaps can be closed.

Ms. Margolies added that CDC received money through the HHS Minority AIDS Initiative this year and will be publishing an announcement through OSTLTS that will provide funding to tribes to work directly on HIV / STD education with youth in schools and through community-based organizations. She said she would let Ms. Cantrell know when the FOA would be published so that she could inform the TAC membership. Chlamydia screening among young women is also a priority for CDC's STD program. In the last two years, they have implemented a campaign known as "Get Yourself Tested and Get Yourself Talking," which has goals about reducing stigma around STDs and getting people to talk about STDs and condoms. This is a joint project between CDC, Kaiser Family Foundation, Planned Parenthood, and MTB. This is usually promoted in March to coincide with STD Awareness month. Collaboration with the Native community around this fits right in to what CDC is trying to do to prevent STDs and HIV among youth.

Two studies were published last year regarding two randomized controlled trials (RCTs) that showed that giving HIV drugs to people at high risk, particularly young women, prevented them from getting HIV infection. This is an exciting opportunity for the HIV prevention community; however, these were RCTs, so it remains to be seen how this will work in the real world. Also, there is not enough money for people who are infected and this would be giving drugs to people who are not infected. Nevertheless, this is a step forward in the field of HIV prevention. The second study pertained to administering HIV drugs earlier in their infection, which was also found to prevent infection. The notion of treatment as prevention could really advance the field. There was a lot of excitement about this during the National HIV Prevention Conference recently. This is a way to treat ourselves out of the epidemic, and it forges stronger linkages for CDC with Health Resources and Services Administration (HRSA) and CMS because there are people who are infected and know it, but they are not in care. Getting those people into care and on therapies will prevent spread of infection. CDC estimates that about 20% of people who have HIV infection do not know it, so it is even more important to find those people, get them linked into care, and get them to stay on treatment.

NCHHSTP is also engaged in viral hepatitis work. The first ever viral hepatitis action plan was released in May 2011. This plan calls for all the federal agencies to work together to address viral hepatitis. Little funding followed the plan, but it connected CDC more strongly with HRSA and SAMHSA. There are new treatments available for Hepatitis C, and there is a lot of excitement in that field as well. There are high rates of Hepatitis C in the Native community, so there are probably areas in which they can work together with Indian Country on that issue.

Discussion Points

- Mr. Petherick wondered whether CDC had had the opportunity to work with the Bureau of Indian Education in these efforts, given their involvement in schools on tribal lands. Many tribal youth do not attend schools operated by the Bureau of Indian Education because they go to regular public schools. Consideration should be given to ways to capture those youth as well, because in Oklahoma, there are instances in which they operate their own high school and are able to bring prevention activities to their schools. Schools operated by the State of Oklahoma, which is pretty conservative, are not allowed to distribute condoms.

- Ms. Margolies indicated that until October, programs pertaining to school-age youth have been part of the Division of Adolescent and School Health (DASH). HIV education programs are being transferred to NCHHSTP as of October 2011.
- Holly Conner added that NCHHSTP has a long history of working with BIE. One challenge is that they have so few staff. They have most often worked closely with BIE on the Youth Risk Behavior Survey (YRBS) every three years. We continue to involve Jack Edmo in all of NCHHSTP's trainings, events, and so forth. It just seems that BIE is limited in resources to do a lot with CDC. However, NCHHSTP always participates in BIE's meetings / conferences, making presentations on the tools the center has to offer. CDC funds the Oklahoma Department of Education and Cherokee Nation for HIV prevention.
- Mr. Secatero indicated that he has an HIV program in the Albuquerque area that used to conduct a conference every year. Now they do this every other year. They have no funding for this, so he was glad to hear that some funding opportunities would be coming out soon. You are right next door so I am going to have my HIV person come and see you. They try to hold a conference during the Gathering of Nations, but are just not raising enough money. They used to bring in people from across the nation to go through this training until there was insufficient funding.
- Ms. Deravello said she usually tries to go to the Circle of Harmony, which she thinks is a fantastic conference; however, it was smaller this year. She had just attended the Rural AIDS Conference in Indiana, which was focused on rural areas rather than Natives specifically. She got much more on rural HIV health issues from the Circle of Harmony Conference than she did from the Rural AIDS Conference. She thought they should discuss ways to increase and beef up Circle of Harmony, because there were a lot of people there from across the country. It was smaller than it had been, but this may just be a sign of the times versus Circle of Harmony's ability to have the conference. She asked where the funds for the conference came from originally.
- Mr. Secatero replied that funding came from different sources, such as private organizations.
- Regarding Mr. Petherick's question, Ms. Deravello indicated that anyone who works with youth in Indian Country knows it is very complicated. There are tribal, private, public, and parochial schools. Some of them are on the reservation and some of them are off the reservation. To implement a school-based project, consideration must be given to what kind of school-based project, who approvals are need from, et cetera. This becomes pretty complicated quickly. The nice thing about working with BIE Residential Schools is that there are really high risk youth in residential schools. Also, youth rely on other youth for information, whether it is good, bad, or wrong. A residential school situation is a really good place to promote peer education. She really enjoyed working with the staff and youth at the BIE Residential Schools. Native STAND was piloted in all four off-reservation schools, but it is difficult to develop a different strategy for every permutation of schools.
- Other than funding, Dr. Holzman wondered whether there were other specific suggestions about how CDC can make improvements in this area.
- Mr. Petherick thought that working with IHS could also include working directly with tribal governments and BIE. When working through all of the convoluted ways to try to reach

children through schools, it is important to engage tribes in the process. Reaching youth can be done through cultural activities as well. Nevertheless, more funding is still needed.

- Ms. Deravello suggested afterschool programs and Boys and Girls Clubs.
- Dr. Holzman acknowledged that regardless of the topic, funding is the number one issue. He appreciates and understands this, but it is also helpful to hear other ideas about how CDC could assist in Tribal communities without getting in the way.
- Mr. Joseph reminded everyone that earlier in the day, there was mention of family planning and parenting and the possibility of being able to bill through Medicaid. A lot of these young people are Medicaid-eligible, so some of the parenting classes that staff offer in the home teach young parents how to parent their children and prepare for the sexually active time in their life. It would save the government a lot of money to allow for this billing so that it could pay for providers to offer that service. Some young families, especially those who are the children of boarding school parents, have lost probably two generations of what parenting is actually supposed to be. He is a boarding school person, but was fortunate enough to take a consumer's education class. However, there was little about how to be a parent. He became a parent at a young age, and for his children, he used himself as a bad example of planning for a family. Young children are having families at younger ages, and there are a lot of broken homes. Many children are in foster care and are bounced from home to home, which also costs the government a lot of money. Funding for prevention will save the government money down the road.
- Ms. Margolies responded that CDC's programs are struggling with some of the issues with payment reimbursement. The STD clinics have never really tried to get reimbursement for some of their services. Under PPACA, some Chlamydia screening is a Grade A service under the US Preventative Services Task Force (USPSTF), so it would be covered without a co-pay. It does not appear that partner services will be covered at all. CMS is now covering behavioral counseling. Right now this is under the Medicare program, but it includes only two visits per year. A lot of what is covered in Medicare ends up being followed by private insurance agencies and Medicaid. CDC is in the process of providing comments about this because behavior counseling is a major part of HIV and STD prevention. Currently, primary care physicians can deliver and be reimbursed for counseling. STD clinics are not primary care facilities, so CDC plans to provide comments to CMS about expanding the definition of a primary care provider. She suggested that others submit comments about that rule.
- Ms. Bohlen indicated that she was in attendance on behalf of NIHB. She is a Sault Ste. Marie Chippewa, the Executive Director of NIHB, and the Chairman of the Board for the National Native American AIDS Prevention Center (NNAAPC). She presented the following testimony for the record:

By the end of 2009, an estimated 3702 AI/AN have been diagnosed with AIDS. By the end of 2008, an estimated 2387 were living with HIV not yet progressed to AIDS, and in 2009 alone, an estimated 189 more tested positive for HIV. By the end of 2008, an estimated 1813 AI/AN with an AIDS diagnosis had passed away. Between 2001 and 2005, only 86% of AI/AN diagnosed with HIV during this timeframe lived longer than three years. This is the lowest survival proportion among all races and ethnicities. NNAAPC recently completed a needs assessment with three native communities, one urban, one rural, and one reservation. Some of the common findings among these three tell us that native communities all have different populations considered at highest risk, whether they be

youth, gay men, or women. Very few communities consider injection drug users as a local problem. These three communities believe that alcohol use is a major contributing factor to HIV transmission. There is still a very low sense of personal risk. People do not believe they will get HIV and that it is still not a local problem. There are no formal information channels through which HIV information is being communicated if it is not happening in the schools or at home among families. There are still deeply held beliefs among most of our cultures that good people do not talk about HIV or sex, and even though individuals know that they should, they are held back from acting for fear of being labeled gay or other things, having lived with AIDS, being disrespected, or experiencing on a reservation level, a social death before experiencing actual death.

The White House released the NHAS for the US in the summer of 2010. AI/AN and Native Hawaiians did not receive much attention in the strategy, save for one recommended action that states continue to examine their surveillance systems to accurately observe the course of the epidemic in these communities. CDC created a new program called the Enhance Comprehensive HIV Prevention Plan (ECHPP). The initiative provides supplemental funding to 12 local health jurisdictions; Baltimore; Washington, DC, Philadelphia; Miami; Houston; Dallas; New York City; Los Angeles; San Francisco; Chicago; Atlanta; and San Juan, Puerto Rico. The reason that I named them is so that those in the room can do the comparative analysis in their heads about how many of those communities would have reservations nearby. Data states that 44% of the people living with AIDS are located within these 12 cities. The ECHPP initiative has turned into a government-wide initiative called the 12-Cities Project where the majority of prevention efforts and funds are being diverted to these urban areas. States in the 12 local health departments are not writing their grant applications, which are due September 14th to CDC to receive HIV prevention monies through the regular HIV FOA. CDC is using a new formula for dividing up money between the states, territories, and the 12 local health jurisdictions.

Here are some of the challenges of this approach from a tribal perspective. Tribes are not eligible for direct funding from CDC under their State Health Department's FOA. Native health entities and tribes can apply for other funding from CDC or from the state health departments, but they cannot compete alongside the state health departments. Money from states with low HIV or AIDs prevalence is being diverted to states with higher numbers of AIDS cases. States like Hawaii, South Dakota, Wyoming, North Dakota, and Montana will see their HIV budgets slashed by as much as 33% the first year and up to 60% over the four years. States with a high proportion of natives in large reservations will find fewer resources available and fewer prevention activities underway. This reflects what one might consider a philosophical shift in the prevention paradigm of the country and of the government. The new thought of treatment as prevention, which means to get people into treatment since new research shows that people with HIV or AIDS who are on the drugs stand a significantly lower risk of transmitting the virus. This means that prevention efforts will no longer be focused on working with people who are negative, but rather looking at populations who are positive. In this instance, it seems to be African-Americans, Hispanic / Latino, injection drug users, and men who have sex with men. This will further de-prioritize the need to work with the American Indian population, as the cumulative AIDS total cases appear to be low.

Potential actions that could happen are that CDC could form a workgroup to streamline the surveillance system for HIV/AIDS and STDs. CDC could work with the tribes to ensure that their data reporting mechanisms are aligned with tribal, IHS, state, and CDC regulations so that all data appears in the national database. Now more than ever, having accurate data on the state of HIV and AIDS in Indian Country is important and vital to sustainable efforts.

CDC should mandate that a set number of state health department HIV prevention demonstration projects be designated for states to work specifically with their native populations and to do so the way those native populations wish to be worked with. CDC could create a plan to deal with the epidemic in rural communities as the current initiative clearly focuses on urban areas. Tribes and tribal coalitions may do well to contact their respective state health departments and advocate to have data on AI/AN broken out specifically in their HIV and AIDS surveillance reports and to be included appropriately and culturally appropriately in applications that are due for the September 14 opportunity. That concludes my remarks, thank you very much.

- Ms. McKinley said she used to work in HIV/AIDS prevention in the early 1990s for about 10 years, and nothing has changed. Everything that Ms. Bohlen brought up was being talked about then. It was mentioned earlier that the data for AI/AN are not accurate. She wondered what efforts were being made to improve reporting, and how CDC is working with tribes to improve the data. Currently, the data are connected to funding and tribes are being passed over because they do not have the data. When tribes and others see those inaccurate numbers, they do not believe there is a problem. Stigmas are associated with being infected, which is still happening 11 years later.
- Ms. Margolies replied that unfortunately, she did not have the technical expertise to answer that question, but that she would obtain a more formal answer from their HIV/AIDS surveillance group. She requested a copy of Ms. Bohlen's document to present to the Division of HIV / AIDS Prevention. She indicated that ECHPP was designed to be a demonstration project. Each area is developing their own plan, and lessons learned from the ECHPP demonstration will be incorporated to the state health department cooperative agreements. They met with another group that was asking for ECHPP for rural areas. That is what they are hoping will happen with the state health department cooperative agreement. The primary focus right now is on people who are infected with HIV since they are the only people who can transmit; however, they are still very concerned about people who are at high risk for HIV. They have not abandoned any kind of approach for HIV-negative folks who are at high risk for HIV infection. NCHHSTP does not fund tribes directly, which she will have to discuss with the division. They have struggled with that because of the number of tribes. The NHAS calls for dollars to follow the epidemic, meaning that it will follow the numbers. This is a dilemma based on the inaccuracy of the numbers.
- Ms. Deravello said that while she is not in HIV surveillance, she is from CDC and is assigned to IHS, so everything they do is a partnership. The screening recommendations are to begin screening for HIV for those aged 13 to 64, prenatal HIV screening, Chlamydia screening annually for all sexually active women under 26, and screening for other STDs for those who test positive for one. Those are the four indicators being tracked in the RPMS data system. These data are primarily from IHS facilities, but some are from tribal facilities that use the RPMS data system. That can be used as an education tool for providers. When communities do not see the numbers, they do not think they have a problem. Sometimes providers look at the numbers and think there is no problem, and they are already understaffed, underfunded, and are working too hard so they are not going to spend a lot of time, energy, and resources on HIV screening. CDC/IHS are trying to tie screening to the indicators that have to be reported on Government Performance Results Act (GPRA) or for other national measures. There are different systems used to measure clinical performance, so one way to get providers to do more screening is by attaching it to the grade they receive. With the movement toward the electronic health record, a lot of places now have coded their systems to provide reminders for providers so that even if someone

presents with a sore throat, the physician will receive a reminder that the person has not had their HIV test, annual Chlamydia test, or that they have screened positive for Chlamydia but have not been tested for other STDs. Hickory Apache and Dulce are doing telephone triage. Someone calls the triage nurse, tells her their problem, and she tells the person whether they need to be seen in person. The Hickory Apache and Dulce triage nurse also has access to the electronic health record, so regardless of why someone calls, they will have access to messages about what tests they need. Many people are trying to determine what to do about racial misclassification. This is a major issue in surveillance. CDC/IHS recently developed a tool kit for screening and treatment that is tailored for IHS and tribal facilities. However, it is available to anyone who wants it. There is a lot of variability in how people are treated from facility to facility, but everyone needs to be treated the same regardless of whether they look like they need to be tested for an STD. The idea of having this protocol is to make sure that providers are using one standard way and using it consistently with all of their employees.

- Ms. Nielson pointed out that elders are also still sexually active at 70 or 80 years of age. Ms. McKinley was aware of a 90-year-old woman who recently contracted herpes. It is important for a toolkit to contain culturally appropriate literature, with pictures of elders as well as teens. HIV and STDs can affect all ages, but elders do not perceive these as their diseases. They think of these as diseases for the younger generation.
- Ms. Hearod said they recently took a road show to their community centers on HIV/STD education for elders. She was worried about it because she did not know how it would be received. However, their elders really liked receiving the information, had a lot of questions, and were really receptive.
- Mr. Antone indicated that his reservation finally declared their STD epidemic over because their rate went back to the normal rate. The tribe advertised heavily on the local radio station using people who speak the O'odham language. He recalled that Dr. Hazel Dean and Dr. Kevin Fenton were working on the social determinants of health and how they could be used to combat this disease or many diseases. He wondered whether this center had thought about trying to use this in some way.
- Ms. Margolies replied that both Drs. Dean and Fenton are still at the center, and the center has actually been doing a lot of work around social determinants of health. They published a Social Determinants of Health white paper. One of the priorities for Drs. Fenton and Dean is recognizing that where someone lives and how they grew up determines how they will turn out. The center is trying to incorporate social determinants of health language in all of its program announcements, so anyone funded through the center should be paying attention to those types of issues. The center published a public health report supplement last year that discussed the state of the field and the social determinants of health. Another one will be published this year. There have been two social determinants of health symposiums on campus at CDC, one just about a month ago and one in 2010. Speakers talked about the importance of social determinants of health. One of the researchers who spoke assessed the death data in Oakland and was able to pinpoint neighborhoods where one could predict where there would be death rates just based on the socio-economics of that area, education, and how much people earn. Addressing social determinants of health has really become a part of how the center is doing its work.
- Dr. Holzman noted that despite limited dollars, there is still important work to be done and there are important decisions to be made. This does not fall on any one person. CDC took

a \$740 million cut this year. Some of that was covered by PPACA funds, but it is not clear where all of the cuts will be realized. This put the agency back to 2003 funding levels, so the agency has taken some steps backwards. Everyone is aware of what is occurring at the national level with regard to deficit discussions. While these are concerns that everyone must be cognizant of, it does not mean that as they move forward, the issues do not need to be addressed.

Tribal Testimonies

**Stacy A. Bohlen, Sault Ste. Marie Chippewa
Executive Director, Media Contact
National Indian Health Board**

On behalf of NIHB, I am here today representing our Chairperson, Cathy Abramson, who is the primary member. I want to acknowledge three members of the board who are sitting at the table. Thank you for allowing me to give this report, following the format that was laid out:

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

NIHB has used the following forums to disseminate information regarding the CDC:

- Social media postings (Facebook, Website, Twitter)
- IHS Tribal Consultation
- IHS Suicide Action Summit
- NCAI
- NIHB Board Meetings
- Public Health Accreditation Board Meetings
- Tribal Public Health Accreditation Board Meetings
- Area Health Board Meetings
- Communication with partners on CDC initiatives and NIHB efforts

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

- Public Health Accreditation
- Need for a Tribal Public Health Policy Institute
- Lack of CDC direct funding and partnership with NIHB regarding Public Health Accreditation
- Lack of Direct Funding from CDC to Tribes
- Diabetes
- Childhood Obesity
- Need for a Tribal Health Policy Institute
- Behavioral Health
 - Suicide
 - Methamphetamine Use
 - Alcohol and Drug Abuse

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

The Public Health Accreditation Board (PHAB) and The National Indian Health Board (NIHB) have partnered in a national effort to improve public health practice in Indian Country. PHAB is developing a national voluntary public health accreditation program for state, territorial, tribal, and local health departments that will launch in 2011. Public health accreditation is a process that will measure the degree to which public health departments meet nationally recognized standards. As the national public health accrediting body, PHAB recognizes the unique and critical role that Tribal governments have in developing the accreditation program. Therefore, PHAB is working with NIHB to ensure that accreditation standards address the specific needs and challenges of the Tribal public health programs. As PHAB tests the accreditation standards, measures and procedures through the upcoming beta test, Tribal health programs will have an opportunity to provide important feedback on the accreditation program prior to the national launch.

The MSPI is a nationally coordinated demonstration program, focusing on providing much needed, targeted methamphetamine and suicide prevention and intervention resources for Indian Country. This initiative promotes the development of evidence-based and practice-based models. These models represent culturally appropriate prevention and treatment approaches from a community driven context. The NIHB partnered with the Indian Health Service and JBS International to provide training and technical assistance to grantees from Tribal communities throughout Indian Country. The program was a three year project that achieved great success. Unfortunately, the economic climate has also affected this programming as NIHB was not awarded funding to continue their technical assistance to tribal grantees. All activities provided to tribal communities are not supported by any grant funds after June 30, 2011.

The Robert Wood Johnson Foundation has also partnered with the NIHB to support the formulation a Childhood Obesity Workgroup to host a series a youth focus groups/talking circles comprising American Indian and Alaska Native youth ages 13 to 17 from five regions of the country. The results of the focus groups will be to inform NIHB on prevention strategies to address childhood obesity from a youth perspective. Thus far, two focus groups have been conducted with three more in line by September 2011. NIHB and its Childhood Obesity Workgroup will provide us the recommendations and guidance to formulate their strategic plan and influence discussion at quarterly workgroup meetings.

A partnership with the CDC has allowed for the NIHB to establish a series of "Think Tank" meetings to discuss environmental issues in Indian Country. Approximately twelve individuals who work closely with their Tribal environment programs have been selected to participate in these meetings in hopes of establishing a comprehensive strategic plan. The CDC is hopeful this coordination and access to Tribal communities will set in motion a detailed plan to address environment risk factors present today.

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

NIHB received a list of the following issues for consideration by the TAC and CDC:

- Tribes feel there are too many consultation meetings held by federal agencies. Tribes are requesting the CDC and other federal agencies work collectively to streamline a

process for consultation. A streamlined process would allow for a more effective and broadened approach to reaching Tribal communities.

- The CDC has identified 6 Winnable Battles; however, tribes feel the chosen battles are not congruent with data driven priorities throughout Indian country.
- The CDC needs to become more actively involved in the Public Health Accreditation process through partnering with NIHB to support in the development of Tribal public health accreditation readiness.
- Tribes (or tribal or Native health entities) are not eligible for direct funding from the CDC under their state health department FOA. Native health entities and tribes can apply for other funding from the CDC or from state health departments, but cannot compete alongside state health departments.
- Money from states with low HIV or AIDS prevalence is being diverted to states with higher numbers of AIDS cases. States like Hawaii, South Dakota, Wyoming, North Dakota, and Montana will see their HIV budget slashed by as much as 33% this first year and up to 60% in four years. States with high populations of Natives and large reservations will find fewer resources available and fewer prevention activities underway.

What additional information would you like from CDC?

- NIHB requests the CDC develop a process for identifying the priorities and sharing results of the consultation.
 - What is CDC doing to address these tribal priorities?
 - What are the results of the action taken?
- A commitment to establishing a government-to-government relationship with tribal governments.
- More enforcement and accountability for States to consult with Tribes on the planning, implementation, and evaluation of public health programming.
- A more direct partnership with NIHB to assist the Tribes in the implementation of Tribal Public Health Accreditation.
- CDC needs to form a workgroup to streamline the surveillance systems for HIV, AIDS, and sexually transmitted diseases. CDC needs to work with Tribes to ensure that their data reporting mechanisms are in line with tribal, Indian Health Service, state and CDC regulations so that all data appears in the national database.

As I had the opportunity to speak with Dr. Holzman and others today, one of the great benefits of a matrix would be helping to keep the tribes informed of the success and the progress that is being made with agencies like CDC. For example, this morning, we had a discussion about transportation and motor vehicle interdiction. When we talk about that issue, without it being in a context, we are talking about a dot on a grid that does not exist. If we were to talk about an issue and say, "That issue first came up in 2008, this is what the tribes asked for, at that moment in 2008, there was nothing. Now there is this. This is not perfect, but this is progress." I think it would be very helpful to the tribes and also very helpful to the agency in developing,

and sustaining, and strengthening our collaboration if we had a document like this that we could look at during every consultation to see that it was addressed on the agenda, and discussed to create a continuum for a discussion of progress, not perfection. Those are the remarks of NIHB and that is our report, thank you very much for making time for it.

Rex Lee Jim
Vice-President
Navajo Nation

Good afternoon honorable Co-Chairs and members of the Advisory Committee, other indigenous leaders, CDC staff, and so on. My name is Rex Lee Jim. I am the Vice-President of Navajo Nation. The President of Navajo Nation charged me with education and health issues on Navajo. Given that authority, I am in a position to make every decision regarding health issues with Navajo. The Navajo Nation is a three branch government. We have the Executive Branch, headed by the President and Vice-President; the Legislative Branch, headed by the Speaker of the Council; and the Judicial Branch, headed by the Chief Justice of the Navajo Nation. We have 110 local political units. We call them “chapters.” According to the Navajo area data of 2010, the total user population is 246,000, but we have more than 300,000 members. We have more than 27,000 square miles of land. We are unique in that three states are geographically located within Navajo.

I would also like to point out that the Navajo Nation has a treaty with the US Government. Nowhere in that treaty does it say that the US will use the states or universities as the middleman. That treaty says that the US Government is going to have a government-to-government relationship with indigenous people, in this case the Navajo Nation. Having said that, we would like to ask CDC, and through that HHS, to deal directly with Navajo Nation in terms of direct funding. We would like to have direct funding to Navajo Nation. Navajo Nation requests recognition as CDC Public Health Emergency Preparedness and Response (PHEPR) fund awardee based on our population. We need to work this out because we have to deal with three states: Arizona, New Mexico, and Utah. I am not sure how we can do this, but we can ask one of the states to be the primary provider for the Strategic National Stockpile (SNS), preferably Arizona. We also need to work it out. As we have stated in the last two days, now we have programs that go directly to Arizona, but if there is an emergency, that program ends at the state line. How can we provide services to Navajo population using Arizona, and then 100 yards away we cannot touch them when they are exposed to the same emergency? We need to resolve that. We also spoke to the issue of CDC helping us work with the states to improve the relationships with the states, and so we need to do that.

We are also interested in the healthcare data—access to it and use of it. For the IHS, the 638 facilities, and the various private organizations, the use of data is important for us to make decisions so that we make informed decisions to offer programs to members of our nations, as well as working with entities like CDC and other programs. We need to do that.

In terms of direct funding, we are now asking for a Navajo Medicaid feasibility study. We understand that we received some funding for that, but we need more and eventually we would like to take over the Medicaid / Medicare program as a nation rather than going through states. Now we are doing that with Arizona, but we would like to do that with the others as well. We truly believe that Navajo Nation is in a position to take care of itself given the opportunity.

We are also interested in education—Head Start and early childhood. That is important to us. We believe that we speak to HIV and we speak to obesity and diabetes. We need to start

teaching them at that level. Two days ago, I mentioned the possibility of having NIEA be a member of this committee, but I was reminded that NIEA consists of individuals. I totally agree with that, but my point is that we need to involve some people from education who will speak to these issues.

The Navajo Nation is doing several things in terms of the Winnable Battles that you are talking about, and here we need assistance as well. For example, with HIV, we are amending our tribal code. We are also dealing with commercial tobacco-free facilities. We are fighting with our own casino. They want to be exempt from this, and our position is "no." We do need funding. We do need assistance with how to do policy work, so we ask for technical assistance at that level as well. The same way with PHEPR. As I shared with you the other day, since June 2011, the Navajo Nation has confirmed 11 new cases of tuberculosis and approximately 250 exposures, so we need help on how to address those critical issues.

I have also shared with you that Navajo Nation is pursuing and developing a Department of Public Health. We will probably have that by fall, October, when the next Navajo Nation Council meets because that is where we are introducing legislation to approve that. After that, we will also be applying for public health accreditation. We need assistance in these different areas of policy development, so perhaps if you have someone in your office that we can share this information with and assist us, either re-wording or something that we are missing or leaving out.

We hope that you rely on our recommendations for improvements to address tribal needs, and most importantly to help us work with the Winnable Battles that we are talking about. We hope that you all also pass this on not only to CDC authorities, but to Secretary Sebelius; IHS Director Dr. Roubideaux, and others. We thank you very much.

Badger Andy Joseph Jr.
Confederated Tribes of the Colville Indian Reservation
Chair, Northwest Portland Indian Health Board

Good afternoon tribal leaders and CDC. My name is Badger. I am Andy Joseph, Jr. I am an Executive Committee Member of NIHB and Chairman of NPAIHB. NIHB represents 565 federally recognized tribes, and it is on their behalf that I present this testimony today. Thank you for the opportunity to present this testimony.

NIHB recognizes the efforts of CDC to strengthen and improve public health infrastructure and perform through various initiatives supported by OSTLTS such initiatives including public health accreditation; National Public Health Performance Standard Program; local and state health department profiles produced by NACCHO and ASTHO respectively; Winnable Battles; and the National Public Health Improvement Program which made funding available to state, tribal, local, and territorial health departments;

A number of economic challenges and infrastructure issues have led to a decline in the implementation of the essential public health services across the US. The essential services, such as disease detection and monitoring vital records and health information technology, are operating at the minimal levels. Program capacity and chronic disease injury labs and environmental health and other areas are at risk. Without the sustained commitment to infrastructure investments and essential public health services, the protections provided by the nation's public health system will fail. We know that performance-based improvements have a strong likelihood to improve the volume and health impact of public health services. Such

improvements include improved efficiency, cost savings, leadership development, and utilization of tools and strategies that improve quality. That is Page 1. I am only going to do 2 pages and submit the rest for written testimony.

Direct funding to tribes—CDC should reaffirm its commitment to establish a government-to-government relationship with tribal governments by committing funding to assist the development of tribal and public health infrastructure. To achieve this, NIHB cannot stress enough the importance of the need for direct funding to tribes and increase of funding allocations to AI/AN. Allocation of CDC funds to states to address public health issues and health disparities does not ensure that funds will actually get to tribes and benefit AI/AN. Many states do not have effective working relationships with the federally recognized tribes located within their state, and do not understand the government-to-government relationship based on tribal sovereignty. Tribes are not subservient to states. Tribes are sovereign nations; however, receiving funds that are passed through states is often difficult and sometimes impossible. CDC needs to hold states accountable for fully engaging tribes in all aspects of planning, implementing, and evaluating public health activities resulting from the use of these resources. CDC needs to enforce the engagement of collaboration with the tribes in an effort to make the greatest impact. NIHB suggests CDC provide states with guidance on working with tribes. CDC is encouraged to provide states with the needed education to understand the government-to-government relationship between AI/AN. Tribes and the federal government—CDC needs to assume responsibility for facilitating this effort to ensure benefits from resources to include tribal communities.

I can give you a really good example of this, when H1N1 first came about and the year before, the scare of the bird flu was real, there were really a lot of good meetings that everyone got to go to and practice for what might happen. Then, when the first outbreak came up on the Secretary's first day of work, she had to deal with it. You do not realize the damage that it did when they sent the vaccination through the state and through our counties. Some of our counties, I believe, were so scared that this bird flu was going to wipe out 70% of their people that they served all of their own first. My daughter was carrying one of my grandchildren at that time and was supposed to be a priority. She had to go across the river to another county to get her vaccination, and that was about 3 weeks after they even came out with them. We lost people and now our tribe has to care for their children. I did a testimony in Atlanta that year, and the following year things went a lot better, but you have to see who we have to deal with before you send something through the state. We had a perfect IHS system that we are used to getting our shots from. They should have been used, but that is just one example.

Tribal / State relations—we commend CDC for supporting tribal / state dialogue, the first of which was held in January of this year. This first step needs to be followed up with additional conversations between the state and the tribes. During the most recent meeting of STAC, tribal leaders suggested expanding this dialogue to CMS. We invite CDC to work with CMS to hold a joint tribal / state relations dialogue soon. An excellent opportunity for the next conversation exists during the NIHB Annual Consumer Conference in September. Both Dr. Frieden and CMS Director Berwick are expected to be present. NIHB offers to host, coordinate, and facilitate this meeting and will invite ASTHO to join us in this effort.

Tribal consultation is an essential fundamental element of federal trust responsibility to tribes. Consultation includes the presence of the highest-ranking tribal officials, tribal elected leaders, or their chosen representatives, and this courtesy should also be afforded to the tribes during consultation. NIHB, therefore, requests CDC Director, Dr. Frieden, and the OSTLTS Director, Dr. Monroe, be present at all the tribal consultations with CDC. We stand firm that their

presence is needed to respect the purpose of tribal consultation, as well as the tribal leaders who make great sacrifices to participate. As well, NIHB requests CDC to create a flow chart of the tribal consultations that CDC has conducted that includes a synopsis of the issues and requests the tribes have brought forward to CDC, actions taken by CDC, and name of the CDC center office and the individual responsible for advancing the representing to tribal concerns. NIHB requests this document is included on the agenda for all future tribal consultations with CDC, and that time is provided to discuss information and determine next steps. In addition, NIHB requests that this information be shared with NIHB for distribution to the tribes and that it is placed on CDC website and updated on a monthly basis. The rest of it I will leave for you to take and use as our written testimony. It is a little more detailed.

I am really grateful that you come here to the Portland area. Sometimes when they see I am from the Portland area, they think that I actually live there. I am about 270, maybe 280 miles from here over the mountain pass. You are on the sunny side of our state and we are fortunate that we have sun here today. This is a really beautiful facility and I am glad that Suquamish hosted the meeting for us. I know there is a deficit and we talked about ways that I think more prevention could actually save the future of the deficit. I hope that you take that message back to your bosses. We will do our part as tribal leaders in legislating with our Senators and Congressmen so that maybe your budget will not be so poor. The IHS has only been funded at 50% of what its needs have been for quite some time now, and we understand how that feels. If the other HHS departments could kick in and help out, I believe it would save a lot of lives. From the Colville tribe, since 2007, October 1, we have lost over 400 of our people. Over 100 of them were under 55 years old, and last week we lost 6 of our people, and that was pretty tough. Our children have to live with that if they get to live at all. Thank you.

Sheri Lee Williams
Council Member
Lummi Tribal Nation

Good afternoon. My name is Sheri Williams. I am a member of the Lummi Tribal Nation. My mother is a Lummi Tribal member and my father was born on the Yukon River. I am elected to the Tribal Council. As of 9 years on the Council, I was appointed to the NPAIHB, which also appointed me as their Substance Abuse and Mental Health Services Administration (SAMHSA) alternate representative. I am also the Treasurer of the Lummi Commercial Company. Our reservation is just about 125 miles north of here. If I would put my canoe out here and paddle North, I would end up in my front yard.

I wanted to share with you some of the positive actions that our Lummi Nation has been able to accomplish recently. Our Planning Department, in following our Tribal Council-approved community development plan, attained American Recovery and Reinvestment Act (ARRA) funds, and that really created some jobs. It helped build us sidewalks along some of the busiest roads on our reservation. We have had a history of many horrible deaths among those horrible roads. We had one man who lost his only two children at different times, years apart. They were non-drinking, non-partying—they just were victims on this road. We have lost many of our youth to the untimely death of accidents, but since we have built these brand new sidewalks, not only along our Kindergarten to 12 school, but also along this busy road between the freeway and the ferry, it is about 50 miles per hour. We have built sidewalks there with the ARRA funds. It is lighted. Every 25 feet there is the power pole and it is solar powered. It is a beautiful sidewalk, and as you walk along this sidewalk and you get close to that next power pole, it triggers it and it gets brighter. This has been a tremendous help to our community. We have also installed some speed bumps in areas that needed them. The Northwest Indian College

has put in a crosswalk so that the students who have to cross the street can actually have the precedence of getting across the street safely. We are planning new road roundabouts, especially on that 50 mile per hour road, to slow these people down and let other people have a chance to get in on the road. Our policy actions have truly decreased the accidents in our neighborhood, and we are trying to keep our communities safe.

I appreciate your conversation here today that you are continuing to outreach to the tribes. I am grateful for the trip yesterday—getting out there and seeing what the people are up against. I know that road out to Makah is really something. We go to the football games out there with my grandkids. That is a trip, especially at night in the fog. It is—oh my gosh, what we do to go to a football game. The Lummi Nation last year, our K to 12 school, we have the Washington State Football Champions of the State.

We look forward to CDC and each and every one of you, and we know behind you are a whole bunch of other people sitting in your office supporting what you are doing here today. We look forward to continue working with you to outreach with the tribes and even the other federal agencies. For example, this ARRA money, to prevent things and make things better, sometimes we need to coordinate different kinds of funding to make a project successful so that our development does make a difference, but it is a lasting development that will last forever. I want you to know that the Lummi Nation, we do have 20-year plan for our water and sewer district because prior to 1973, we did not have that. We had outhouses and untreated well-water, and many of our people were very sick from that. The septic tanks—it rains here all the time, and the kids were playing in sewer. It was really bad, and so to prevent illness, you have to have a healthy living condition. That was a real thing to do that, and we are thankful that we have that. I am also an appointed member to the water board, so I try to do my best on that.

I want to jump to another subject about the suicide attempts. We had one just two days ago. It was a young man who was injured. He was 38 years old. Thank goodness he did not commit suicide, but he was injured in September. They could not do an operation. The muscle on his hip was torn off his hip bone. There was just no surgery available in Seattle until January because they said there was only one doctor that could do that, so he had to wait from September to January in total pain—a lot of pain pills. After this surgery in January, more pain pills, and where is the help to get him the proper help to get off those pills? He is really depressed, he cannot work, and so what do you do? He had to move back in with his dad. He is a single man, but he is a good man. The other girl, her father was stricken with a heart attack and she thought her father was going to die. She said that she cannot live without her dad, and jumped off the bridge into the river, and she hit the sand bar. Somebody saw this happen and they just stopped their car. They swam across the river to the middle of the sand bar and saved her. What if the sand bar was not there? Her father survived. Suicide, depression—we know of dysfunctional families, the drug use, and we are trying to combat that. In the Lummi Nation, we recently added \$650,000 to the police department for drug prevention. It is coming along, but you take those drug dealers out and there are more in line. It is bad, especially since we live near Canada. They have such access to drugs over there and the drug smuggling. We have actually had our own tribal members caught at the border smuggling drugs.

I appreciate your conversation on the teen pregnancy and the STD awareness. I just wanted to express the gratitude today that we tribes, and especially our Lummi Nation, have for CDC for undertaking consultation session from the tribes today and every day. Thank you very much for your time.

Joe Finkbonner

Northwest Portland Area Indian Health Board

It is sort of cultural whenever there is one Lummi, another has to come to the table to add to the comments. First of all, I want to sincerely state my appreciation to everyone that made the trip out for the tribal site visit yesterday. It is a fundamental principle of our tribes that you need to come out to see where we live in order to understand the challenges that each of our tribes face. I really thank those of you that made the trip for doing so, because it does mean a lot to them that you have walked in their moccasins for at least a brief moment in time and realized the challenges that they face. My hands go up to you all for enduring the long bus ride out and bus ride back. So thank you for doing that.

I am here to talk to you today—over and over you have heard the theme about please hold states accountable for working with tribes. I want to give you one specific example where the State of Oregon actually reached out to the tribes in Oregon through the CTG that is underway right now. There was a technical assistance phone call that was just recently made with all the applicants where the State of Oregon was told essentially it would not be considered because the tribes are considered geographically separate entities and they would have to apply separately from the State of Oregon—essentially, the very principles that we are asking, and that is to make the states accountable for working with the tribes. Oregon tried to do that, but then was later told that their grant would not be considered or scored as high if they included the tribes, even though all 9 of the federally recognized tribes were supportive of the application. I hope something can be done about that. I hope that in situations where you have all of the federally recognized tribes within a state in agreement in an application, I would hope that CDC would find a way to circumvent those types of rules so that it is beneficial for those small tribes that do not have the infrastructure to apply for a grant independently from a collaborative. Thank you for listening and thank you for being here.

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

First, I wanted to thank all of the CDC personnel for coming out for the consultation and thank my colleagues around the table for all of the information they share in support of one another. I would also like to extend a big thank you to the Jamestown S'Klallam Tribe and Makah for hosting us yesterday. It was amazing, and I just felt welcomed at both places, so thank you. I wanted to put on the record some of the concerns and the points that we wish to have taken away from this meeting, the first being our official request to lower the threshold for that grant opportunity, or any grant opportunity for that matter. To completely take away an opportunity from a whole area is concerning to us.

The second would be just to highlight some discussion that we had during our TAC meeting on data. With health reform, there are lots of requirements of improving health information technology and the care for American people, including Native Americans. I would like for CDC, if they could, to help us access AI/AN-specific data. A lot of the data available on CDC websites are specifically for White, Black, and Other and there is limited data on AI/AN people. I request that you start including AI/AN-specific data in CDC's National Oral Health Surveillance Systems, making it easier for tribes to compare themselves with other populations. The other thing that gets back to the data is, as we talked about on Monday, Tribal Epidemiology Centers have limited funding. There is only so much we can do with \$300,000 or \$400,000, so it would be great if CDC could look into—I know it is going to be hard with these economic times—but

providing some funding to Tribal Epidemiology Centers to look at these types of things. Maybe look at ways, I am not even sure that tribes would be open to this, but look at ways of linking CDC data, look at linking CDC Resource and Patient Management System (RPMS) National Data Warehouse Data, so that we have one big data pool to pull from and we can provide much better population health reports. Those are the things that I would like for you to take away from this meeting, and I thank you all.

Dotty Chamblin
Makah Tribe

Thank you. My name is Dottie Chamblin. I am Makah Indian from Neah Bay, Washington. I am thankful for all the praise that the Makah received. I have been noticing some necklaces here that people must have gotten. They look good on you.

I am here to talk about the language. I am an Indiana Shaker Minister, 1910 Makah, but I would like to have us recognized for the lands that we ceded that entitles to us to the treaty right to healthcare. During that treaty time, our medicine men, Indian medicines, language, and songs, were taken away. Doctor True Heal had an initiative that came out and lasted a few years and seems like it died. However, the Veteran's Center has that operating in the Veteran's Administration (VA) where a Native American vet can ask for a medicine man or a shaker and it works. His idea was that you would spend \$10 million on a patient, give them all kinds of Western medicine, and never heal them, but you bring in a spiritual leader, they can interpret it, and take it off, and heal them. It did work at the time he was working on it.

I did not hear actually the words "mental health." There is a 12-year-old boy who has brain "big mile long word." He is a special needs, and he attempted suicide on my reservation. Two days ago a grown man with fibromyalgia prayed to God that he would die, that God would take him from here. The suicide has its prevalence among our people because of the way IHS has done and the funding of America. In the newspaper today at Neah Bay they said that 2014 is when Social Security might be fizzled out. There will be no more money. That puts an added burden on our Makah healthcare, and everyone else's healthcare. I hope you will take that into your heart what fears that each of us on our little reservation go through.

My neighbor has Chronic Obstructive Pulmonary Disease (COPD) and she has a difficult time going to the hospital in Port Angeles. There is a white doctor there named Dr. Anderson who told her, "Indians are just depressed. You do not deserve that pacemaker you have. I am not going to give you this 14-blood workup thing." She gets upset in her heart attack condition and is going to walk out. He said, "No, I am going to put you in a rest home so we can study you." The nurse was a witness as was her husband. This is at Olympic Memorial Hospital in Port Angeles, 72 miles from Neah Bay. She makes a complaint at the clinic and they told her that all they could do is send her back under the care. She made a complaint before she got out of the hospital. The doctor was sent down to apologize to her, but it was too late, she was on her way home. She was not going to stay.

So we have additional problems. The whole Port Angeles area takes contract health, and in the beginning, we made those guys rich and now we are at the end of that money and they do not want us. They do not want Medicare, they do not want Medicaid, and people are being denied and have to find another doctor that will take them. I wanted to make sure that mental health was there, not only for the Native American vet, but I just got back from Camp Chaparral working with Post Traumatic Stress Disorder (PTSD) and interpreting it to the VA officials very much like this consultation. Interpreting our needs in what the Native American does not ask for

or does not say and do not know what to do when they get to the door, how to ask for a work up. We are beginning to need to have another person come with us to help us discuss those needs with the doctor at hand.

We need research done, for instance on fibromyalgia. That is a brand new thing that they do not want to treat. That is all I have to say. I want recognition for our people that ceded land to have this sovereign entitlement—aboriginal entitlement. This land is Suquamish. It is my mother's country. In my mother's country, we received the best medicine here for bleeding ulcers, cured in 10 days. This country has medicine for high blood pressure here in Suquamish, kidney disease, bladder, cirrhosis of the liver. When the liver gets like hamburger, it will cure it. That is where our healers come in. I would like to have recognition for the Native American population, the one ethnic group that gave the most sons to each and every war. Some of them still suffer at home with PTSD and go through those wars. They do not want to go to the clinic for treatment of leukemia or cancers—things that are going to cause them to die. They want to die.

Sheri Lee Williams
Council Member
Lummi Tribal Nation

Thank you, Dottie. I would like to say that there is a lot here in the Northwest in Indian medicine. I know my mother had taught me what trees to go out and get, and strip the bark off the trees, and take the inner bark and boil it up. It cures eczema. If you have total raw hands or face from eczema, you just wash with it for three or four days, and then the next week and the next week, and it is totally gone, and it never comes back. There is a lot of medicine here in the Northwest and we are losing it. That is the scary part, a lot of these kids, they do not want to go out in the woods and make all these medicines that really truly exist here. It stays in the reservations and the families, but it could really help a lot of people. Thank you.

Rosemary Anthuunaguak
Barrow Alaska

Hello. My name is Rosemary Anthuunaguak. I am living in Barrow, Alaska. There has been a lot of good discussion, and there are some possibilities for some good actions. In Alaska, we have a different view of some of these opportunities that you are making available. I worked with the Chemical Toxins Working Group in trying to use the internet in trying to research the information that was necessary to participate in that process. It is not a reality in rural Alaska. Having internet in that community does not mean it is accessible. At the time, especially when we have small communities, our one worker that was assigned to open up this facility had some losses in her family, 3 in a row. She was not there for 3 weeks, and it was really important for me to access this information in a timely manner, and I could not do it. You are putting out a lot of information that is available in these new technologies, but is it a real resource in these rural areas? It is not a real resource in some of these communities. Do you really think that some of the kids are going to go into this school and look at some of this information where it is not a private setting? That is where most of our village kids have access to the internet, through the school setting. It is not available after hours. We are lucky if the library opens 10 hours per week. You need to look at the bigger perspective of these types of resources that you are making available as an answer for rural Alaska.

There are a lot of concerns for our communities and there are efforts to bring out these concerns in many different ways. Bringing a forum like this together allows us to feel more

comfortable to come in and present some of these concerns. When I had an injury to myself, the doctor told me, "You are too young to be hurting. Get up and get out of here." That was the only resource I had available in my village to go and get help when I dislocated my hip. It was out for 4 days, and I am still waiting for that referral to go and see an orthopedist. These are the kinds of services we are having in our villages.

I worked to bring pediatric clinic into my village because I had 37 kids that needed to be seen by the pediatrician. It would have taken 7 to 10 years to get those 37 kids seen one time. This is the system that is looking at some of the databases that you have to assess some of our health effects, but we have not had stability in our healthcare providers. Before I went to the University of Washington to become a physician's assistant, I worked with 150 different doctors. Who is in-putting their data? Who is following up on these patients? These are the realities of rural Alaska, so I hope you look at things in a better way. Thank you.

Badger Andy Joseph Jr.
Confederated Tribes of the Colville Indian Reservation
Chair, Northwest Portland Indian Health Board

This young lady that just spoke reminded me of something that I am really worried for as an Executive Committee member of NIHB. We do represent the Alaskan area. A few years back, I was up there for an HHS consultation in Anchorage and on the news, Native Alaskans were meeting up there about subsistence rights to hunt and fish in their territory. As you know, they are one of the last states to become a state in the nation, and the deal that was forced on them only granted the subsistence rights to the Native Alaskans that were alive at that time. It is coming to the time where a lot of them are now elders, and that right is not going to be passed on through the generations. I will use my tribe as an example. We had probably one of the biggest fisheries in the Northwest. Our leaders went to the World War and come home, and the fishery was gone because they built the Grand Coulee Dam. So now we have to travel, some of our people, over 100 miles to go catch salmon. For people that relied on salmon for an average of 80% of their body intake food for over 1,000 years or more to all of a sudden have that taken out of their diet was a tremendous shock to our body, and what makes everything work right. Diabetes and heart disease are really a big factor. My worry for the Native Alaskans if they get rid of their right to subsistence fish and hunt in their territory, then I would imagine more diseases are going to come to them. I really would encourage CDC to pass this on to your superiors as a warning, so that maybe there could be some way that the Native Alaskans will be able to continue to do their subsistence fishing and hunting. To me, it will save the government more money than having to deal with epidemics that are going to come if you do that. Thank you.

Chester Antone, Co-Chair
Councilman, Tohono O'odham Nation
Albuquerque Area Representative
Chairperson, Albuquerque Area Indian Health Board

We do not have anyone else, so I would like to say a few words before I turn it over to you, Mr. Holzman. A lot of the testimony, a lot of the remarks made by the committee members, go back to at least 4 years ago when I came on board. The reason they keep coming up is because we have not figure out a way to make those things happen, like direct funding. Some of them are legislatively mandated to go to states, but I think some of the effort that CDC has made in the past is to hold states accountable for ensuring that tribes get some service out of that.

Data comes up more and more because Congress is using that data to appropriate funds, and that becomes real important, especially if we have access and assistance to isolate Indian things that pertain to the Native American, because that makes our argument stronger. If we do not have that data, we are not really counted. We are counted in a population, but that does not mean that there is recognition of the number, or the instances, or the high rates of suicide, alcoholism, and whatnot. I sit on another committee called the Health Advisory Council at HHS, and we constantly discuss the issue of having data within our nations, coming from our nations, assessing us within our communities, and whether that data is acceptable to federal agencies. Federal agencies mainly look at states and IHS, but what about those that we come up with within our communities when we try to assess our communities to find out what programs we could come up that will work with us—learning about kinship? That it is not just for us. For us, it is a term of endearment. For the outside, it has to do with wills. Who is going to get this money after someone passes on? It identifies people. In our way it is like when you go to the shop you are saying, “How are you, cousin?” or “How are you grandpa?” It is quite different than other things that will not be accepted by federal agencies even though we know. When you talk like that, when you put that personal thing in there, from there you start to get the caring of your own people. We have a very hard time with federal agencies being able to understand that. It may take some time to develop it, but the project manager is saying, “You have two more months to come up with this plan.” How are you going to do that? First of all, are you going to even recognize what we are going to give to you? Are you going to tell us to go to IHS and get our data, or go to the state of Arizona and get your data? They will tell you what you need to do with your focus on motor vehicle accidents, and then we look at our data and we say we do not have that many people with access to cars because they cannot afford it, but that will not fly. What I am saying is that across the federal agencies, we really need to have a feel of that, and maybe somewhere down the road we might ask CDC to support us when we approach the National Institute of Health (NIH) to support us in that way. They can look at us and be able to understand how we are going to address that issue, because if we do not, we are not really addressing the issue there with the states. I just wanted to throw that into the mix.

I would like to ask that you let Dr. Frieden know if he could possibly attend the Consumer Conference in Alaska that we will have all 3 players: IHS, CMS, and CDC. If you recall, some of you, maybe you were there at the STAC meeting in May, Dr. Judith Monroe suggested that there be a meeting held among the 3 agencies to talk about the impacts of Medicaid, things like maintenance, or in Arizona, the elimination of children as adults, which directly impacts contract health services—those types of things that may be discussed there, and we need to figure out what else we need to do. I know that the State of Arizona cannot do that because it is input in a way where I do not know anyone. Is it 87 or 78? I am getting those things mixed up, but a new application that is supposed to go into effect in October. I think that has probably been continued because of the controversy with it. Roe got on board to delay it, particularly in Arizona, and 45 other Congressional people. The stakes are very high when you consider IHS. That is why you have, for a long time, another way of saying direct funding as it pertains to CMS. It is the 51st state concept that Native Americans are beginning to address. You heard Navajo about the IHCI A for that purpose. We are being forced to look at it, so if we are being given 80% reimbursement for transportation, which they already alluded to on Monday, is that public health? Is giving transportation and referrals for dialysis off the reservation public health? If they are giving us that much and CMS does not have justification to provide 100% full reimbursement, then we need to take a look at our transportation document and give them that justification, and we hope that they will take a look at it. We are planning to do that in September with the Tohono O'odham Nation, and we hope to have an audience with whomever has decision-making authority at CMS to take a look at our transportation document.

Even though it does not seem to be a public health issue, it really is. It contributes to the overall HIV / AIDS, and the reason why I ask you about the social determinants of health is to me, that is really important. I think the PPACA tries to address that in some way, although it does not outright state it. Prevention and living a good healthy life contributes to you, and humans are more productive when it is like that. I am sure that we are not going to eradicate illnesses, but at least we can bring it down to a level that we can manage. Women's health, they just talked about it, I believe that is a social determinant. They are the ones that bear the children. The income distribution or the distribution of wealth, we understand perfectly, I think everybody understands when you go to the Makah Tribal Community and you look at the houses, and some are very nice and some are in disrepair. Then we have cars sitting out there. It is really strange out on my reservation. There are cars by the house that are broken down, but in Makah it is boats.

I cannot stress enough the importance of we need to ask our tribal communities, "Are you satisfied with where you are?" The reason why I travel is because the department or CDC, they provide me travel so that I can go and engage in conversations and discussions. On my reservations, some never see the land past Phoenix because they do not have that access. They cannot go to an airport to fly out to Vegas or to fly out to Suquamish. I am very grateful that I have these opportunities to speak to some of the health agencies on these issues that I see. I want to have CDC to at least to come away with the understanding of where we are and why we talk this way. It is real.

Wrap-Up / Closing Blessing

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

**Andrew Joseph, Jr.
Confederated Tribes of the Colville Reservation
NIHB Member at Large and Portland Area Representative
Chairperson, Northwest Portland Area Indian Health Board Chairperson
Tribal Council Member, Confederated Tribes of the Colville Reservation**

Dr. Holzman thanked everyone for their honesty, conversations, and input. While he thought it had been a good meeting, he emphasized that what makes a really good meeting is what occurs afterward. OSTLTS will follow-up and move things forward. He noted that at this point, he was going to call people by their first names, because he now has a tradition that if he travels 3 ½ hours with someone on a bus, they are friends and should use first names. He thanked Kimberly and Melanie from the OSTLTS office for putting together this meeting, Chester and Kathy for their hard work during various meetings and in other efforts, and the Northwest Portland Area Indian Health Board for serving as their host and arranging the accommodations and site visits.

He heard a lot during the meeting. Ursula did a good job presenting her information based on issues raised during the February Tribal Consultation. While he was not in attendance at that meeting, clearly many forward steps have been made. Stacy's point brought forward the grid, which places the responsibility on everyone to make things move forward. He said he wanted to work further with Stacy as OTLTS becomes better-established. They soon will have the Tribal Director on board, and will fill the two support positions for the Tribal Director. Clearly,

they need to coordinate better within CDC on tribal issues. These are financially tough times and difficult funding times. Given that, it is important to prioritize on paper in order to remain focused and achieve important goals. Also important about developing a grid is the large US bureaucracy with many different entities, all of which have their specific mandates. Regardless of these mandates, they must all work together on a common goal. Chester and Rex Lee brought forth the aspect that all of the entities within the federal government must work better together to be successful. OSTLTS will continue to try to push that forward. He also recommended raising this issue during the next STAC meeting. It would be extremely beneficial for Secretary Sebelius and others to tell the sister agencies that they need to work better together.

Lester raised the issue of having someone to talk to and with whom to exchange information. One of the challenges in a huge bureaucracy is “the bureaucratic shuffle” of not knowing who to call or what to call. Dr. Holzman expressed his hope that his office within OSTLTS would be the place to make first contact. They may not always have the answers, but they can help guide people in the right direction so that they do not have to waste 4 or 5 days just trying to get to the right person. JT and others raised the issue of the importance of highlighting the great successes occurring in Indian Country. CDC uses three points in “Have You Heard” and he heard way over three points. He invited everyone to send emails to him describing some of the successes, a few of which they heard about over the three days of these meetings. He was very impressed to see that the casino he visited in Browning, Montana had adopted a smoke-free policy.

He heard repeatedly from Dee and others that data is critical and requires significant attention and work. He said he wanted to spend some time better understanding the issues, and working with others to determine the next steps needed to move things in the right direction. Andy, Rex Lee, and others emphasized the importance of working on tribal / state relations. There was a successful meeting in the Winter regarding this issue, and the goal is to move forward with a second meeting. OSTLTS is also trying work with some of its partners. It was great to have the tribes, states, and ASTHO together. However, the next meeting will be an even better meeting if other federal partners are in attendance, such as CMS.

In conclusion, Dr. Holzman thanked the Cambridge Communications & Training Institute (CCTI) writer for capturing and archiving all of the information from the three days of meetings, as well as those in Suquamish and the Makah Tribe for their hospitality.

Mr. Joseph offered the following blessing to officially conclude the 7th Biannual CDC / ATSDR Tribal Consultation Session: Magnificent Creator, I ask that you bless everyone of us, our people and our families, and to bless us all as we travel to our homes, that everything will be better than when we left. I pray that the Creator will watch over us and we all have a safe trip. Put into our minds and our hearts everything that we spoke of here today so that when we go home, we will go home with a new confidence.

With no further questions / comment raised, Mr. Antone officially adjourned the meeting.

Attendant Roster

Tribal Consultation Advisory Committee (TCAC) Members

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

Other Tribal Organizations / Tribal Health Boards / Tribal Health Professionals

Rosemary Anthuunaguak, Barrow Alaska
Stacy A. Bohlen, Sault Ste. Marie Chippewa; National Indian Health Board
Dotty Chamblin, Makah Tribe
Julie Kimble, MS, Cherokee Nation
Badger Andrew Joseph, Jr., Confederated Tribes of the Colville Reservation, Northwest Portland Indian Health Board
Martha Pearson, MA, ACSM, South East Alaska Regional Healthcare Consortium
Mike Tryon, Salish Kootenai College
Marilyn Wandrey, Suquamish Tribal Member
Sheri Lee Williams, Lummi Tribal Nation

Centers for Disease Control and Prevention

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

Other Guests

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