

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

6th Biannual CDC/ATSDR Tribal Consultation Session

February 3, 2011

Meeting Minutes

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Acronyms

ACHIEVE	Action Communities for Health, Innovation, and Environmental change
AI / AN	American Indian / Alaskan Native
AI-ATS	American Indian Adult Tobacco Survey
<i>AJPH</i>	<i>American Journal of Public Health</i>
ANHB	Alaska Native Health Board
ANHC	Alaska Native Health Consortium
ARRA	American Recovery and Reinvestment Act
ASTHO	Association of State and Territorial Health Officials
ATSDR	Agency for Toxic Substances and Disease Registry
BIA	Bureau of Indian Affairs
BRFSS	Behavioral Risk Factor Surveillance System
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CEEDS	Excellence for the Elimination of Disparities
CPPW	Communities Putting Prevention to Work
CMS	Centers for Medicare and Medicaid
CRIHB	California Rural Indian Health Board
CVD	Cardiovascular Disease
DACH	Division of Adult and Community Health
DASH	Division of Adolescent and School Health
DHS	Department of Homeland Security
DNPAO	Division of Nutrition, Physical Activity, and Obesity
DOI	Department of the Interior
DOJ	Department of Justice
DRH	Division of Reproductive Health
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcements
GDLs	Graduated Driver's Licenses
GLITC	Great Lakes Inter-Tribal Council
HAIs	Healthcare-Associated Infections
HCW	Health Care Worker
HHS	Health and Human Services
HUD	US Department of Housing and Urban Development
IHS	Indian Health Service
IOM	Institute of Medicine
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSM	Men who Have Sex with Men
MTUPP	Montana Tobacco Use Prevention Program
NACCHO	National Association of County and City Health Officials
NACDD	National Association of Chronic Disease Directors
NALBH	National Association of Local Boards of Health
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCIPC	National Center for Injury Prevention and Control
NDWP	Native Diabetes Wellness Program
NIHB	National Indian Health Board
NNAAPC	National Native American AIDS Prevention Center
NNCTAPN	National Native Commercial Tobacco Abuse Prevention Network
NPAIHB	Northwest Portland Area Indian Health Board
NRPA	National Recreation and Park Association
NWTEC	Northwest Tribal Epidemiology Center

PHAB	Public Health Accreditation Board
PRAMS	Pregnancy Risk Assessment Monitoring System
OD	Office of the Director
OSH	Office on Smoking and Health
OSTLTS	Office of State, Tribal, Local, and Territorial Support
PAIHB	Portland Area Indian Health Board
PedNSS	Pediatric Nutrition Surveillance System
PHER	Public Health Emergency Response
PNSS	Pregnancy Nutrition Surveillance System
PRAMS	Pregnancy Risk Assessment Monitoring System
PTHA	Puyallup Tribal Health Authority
REACH-US	Racial and Ethnic Approaches to Community Health Across the US
RWJ	Robert Wood Johnson
SDPI	Special Diabetes Program for Indians
SME	Subject Matter Expert
SNTPN	Southwest Navajo Tobacco Prevention Network
TCAC	Tribal Consultation Advisory Committee
TSCs	Tribal Support Centers
USDA	United States Department of Agriculture
VA	Veteran's Administration
WISEWOMAN	Well-Integrated Screening and Evaluation for Women Across the Nation
YPLL	Years of Potential Life Loss
YRBS	Youth Risk Behavior Survey

**Centers for Disease Control and Prevention (CDC)
Agency for Toxic Substances and Disease Registry (ATSDR)
Tribal Consultation Session**

**Minutes of the Meeting
February 3, 2011**

Call to Order / Welcome

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

Kathy Hughes called the meeting to order, welcoming those present. She then requested that Kaipo Akaka offer the opening prayer. Following the prayer, Ms. Hughes announced that Dr. Frieden would soon join them to discuss the winnable battles and his goals and objectives for the Centers for Disease Control and Prevention / Agency for Toxic Substances and Disease Registry (CDC / ATSDR). She expressed her hope that the tribal leaders had also prepared their comments pertaining to their respective issues and concerns, as well as any issues that align with the winnable battles. She emphasized that funding is always going to be an issue, which may be an even greater challenge moving forward based on the discussions the previous two days. They must be prepared to work hard toward developing collaborations and coordinating working relationships to utilize the funding they receive to the best of their abilities. Clearly, much more can be done to build and enhance collaborative efforts.

CDC/ATSDR Winnable Battles: Overview

**Thomas R. Frieden, MD, MPH
Director, Centers for Disease Control and Prevention
Administrator, Agency for Toxic Substances and Disease Registry**

Dr. Frieden said that it was his pleasure to attend the Tribal Consultation Session again, and that he really enjoyed last year's meeting. He apologized for the format of the room, which was not very conducive to a roundtable discussion. He then reviewed the "winnable battles" and health goals. He emphasized that for him, the winnable battles concept is a very important one.

In the 18 months that he has been at CDC, Dr. Frieden has worked to ensure that the organization is optimally structured to deliver results in the following key area:

- Excellence in surveillance, epidemiology, and laboratory services to know better what is occurring
- Strengthening support for state, tribal, local, and territorial public health
- Increasing global health impact
- Using scientific and program expertise to advance policy change that promotes health
- Better preventing illness, injury, disability, and death

Each area of the winnable battles is a leading cause of illness, injury, disability, and death. There are evidence-based interventions that can be scaled up to make a difference. Results from such efforts can likely achieve results within 1 to 4 years. However, none of these efforts is easy. In order to maximize health benefits, Dr. Frieden identified six focus areas (e.g., winnable battles) where CDC wants to do more, which are as follows [<http://www.cdc.gov/about/winnablebattles.htm>]:

Tobacco

Tobacco is the leading preventable cause of death in the US. However, after 40 years of progress, the decrease in adult smoking rates has stalled in the past 6 years. But most people who have ever smoked have already quit, and most of today's smokers want to quit. American Indians / Alaska Natives (AI / AN) adults have the highest smoking prevalence of any group [National Health Interview Survey, 1978-2009; data aggregated for selected years]. CDC is dedicated to reducing the death and disease caused by tobacco use and exposure to secondhand smoke. When Dr. Frieden was in college, he facilitated a guest residency at the college he attend of a group called "Women of All Red Nations" who were there for a week. They had many intense discussions and at the end of the week, the sponsor wanted to have a more personal discussion with the women leaders who were present. The women said, "We always knew that tobacco was really dangerous and that you should only use it for ceremonial purposes once a month or so. You stole it from us, and it's killing you as a result." This was quite a striking thing to hear. Traditional ceremonial uses of tobacco were quite limited, but since the product was commercial and sold for profit, it became the leading cause of suffering and death in all communities.

Obesity, Nutrition, Physical Activity and Food Safety

Obesity rates have doubled for adults and almost tripled for children in one generation since the 1960s. Almost three quarters of AI / AN adults are overweight or obese [Vital and Health Statistics, National Center for Health Statistics, 2010]. CDC is committed to addressing the epidemic of obesity and overweight in the US and improving the public's health through the promotion of good nutrition, physical activity, and a safe food supply. Obesity is getting worse very rapidly and is resulting in major social and economic costs. While they do not yet know how to reverse it, CDC is going to try. Over 36% of adults (>72 million) and 17% of children are obese. Each year, foodborne diseases sicken 1 out of 6 Americans and cause greater than \$9 billion in health care-related costs. CDC is working in partnership with the Food and Drug Administration (FDA) and United States Department of Agriculture (USDA) to increase the safety of the food supply. CDC's work is largely focused on detection and response, but they want to move a few steps back in the chain to assist with prevention efforts.

Healthcare Associated Infections (HAIs)

CDC is committed to eliminating preventable infections that occur as a function of medical or surgical conditions. HAIs are one of the top 10 leading causes of death in the United States (US), accounting for an estimated 1.7 million infections and 99,000 associated deaths each year. HAIs cost approximately \$30 billion per year and are highly preventable. In the in-patient hospital setting, 1 out of 20 patients contracts an HAI; 100,000 patients die each year from an HAI; and HAIs costs range between \$26 to \$33 billion per year. In out-patient settings (e.g., dialysis, laboratory, long-term care) patients can acquire bloodstream infections. At least one third of HAIs are preventable with simple, existing tools. CDC has in place the National Healthcare Safety Network (NHSN). Greater than half the hospitals in the United States are now reporting to the NHSN, which will help to improve the quality, quantity, and comprehensiveness of that reporting system, as well as contribute to prevention efforts.

Motor Vehicle Injuries

Motor vehicle crashes are the leading cause of death among Americans ages 5 through 34. Despite progress, US rates of death from car crashes are twice the rates of other countries and could be reduced by simple, low-cost, existing methods. Twice as many AI / AN die in motor vehicle crashes as whites [National Vital Statistics System, 2003–2007]. CDC actively supports evidence-based interventions such as primary restraint laws, graduated driver licensing, and DUI interlock devices to drive down deaths and injuries from motor vehicle crashes. There has been recent progress in this domain in that teen fatalities have fallen substantially in recent years. This is probably the result of a combination of factors, including the expansion of graduated driver's licenses (GDLs). While populations in other countries may drink just as much as those in the US and drive faster, the US has one-third of the fatalities in motor vehicle injuries. Motor vehicle injuries remain the leading cause of death in young people in the US, but these are preventable.

Teen Pregnancy

Teen and unintended pregnancy rates in the US are 5 to 10 times higher than in other countries that have just as much sexual activity as the US. Such pregnancies often result in the intergenerational transmission of poverty. Since the 1960s, rates are far lower and are decreasing much faster in other countries. Effective efforts in this area have the potential to drive rates down by at least 50%, and to subsequently have a major impact on reducing social inequality. CDC works to prevent teen pregnancies that contribute to poor health and negative social outcomes through evidence-based strategies, policies, and systems change.

HIV

HIV continues to spread despite being preventable. HIV infections, particularly among men who have sex with men (MSM), have fallen and then risen again, with an epidemic now observed in this population. CDC provides leadership in reducing new HIV infections through awareness of HIV status, prevention for positives, prevention for high risk negatives, and elimination of health disparities. HIV rates have been stable for many years, but it is still an incurable infection that changes people's lives forever. Understanding more about HIV can drive infections down.

Improved cardiovascular care could save 100,000 lives per year in the US [Farley TA, et al. Am J Prev Med 2010;38:600-9]. This can be done with the ABCS: Aspirin Use, Cholesterol Control, Blood Pressure Control, and Smoking Reduction / Prevention. The ABCS offer the greatest potential to save lives and reduce health inequalities. CDC is promoting the ABCS to systems, clinicians, and the public. Electronic health records (EHRs) can be key to facilitate improvements, including decision support; establish monitoring and feedback; facilitate panel-based management; improve information transfer, including pharmacy data; and provide accurate information for evaluation and improvement. Despite spending \$1 out of every \$6 on health care (~\$2 trillion), on the ABCS, the US gets an F. Only 33% of people at increased risk of cardiovascular disease are taking aspirin, only 46% of people with hypertension have adequately controlled blood pressure, only 33% of people with high cholesterol have adequately controlled hyperlipidemia, and only 20% of people trying to quit smoking get help.

A report recently released by CDC showed that in almost all instances, AI / ANs have disproportionate health needs [MMWR; CDC Health Disparities and Inequity Report—United States, 2011]. Inequalities are all large, persistent, and increasing. The National Association of County and City Health Officials' (NACCHO) Health and Social Justice Committee stated that, "Inequalities in health status in the U.S. are large, persistent, and increasing . . . poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities." AI / ANs face health

disparities with a life expectancy almost 5 years lower than the US population, and disproportionate disease burden linked to adverse socio-economic conditions (e.g., low education, high poverty, high unemployment, unsafe communities, inadequate housing, discrimination in the delivery of health services, and cultural differences) [Indian Health Services].

Factors that affect health at the most basic level are socioeconomic (e.g., poverty, education, housing, and inequality). One level above that is changing the context for health to make individuals' default decisions healthier (e.g., fluoridation, zero trans-fats, iodization of salt, smoke-free laws, tobacco tax). Then there are long-lasting protective interventions (e.g., immunization, brief intervention for alcohol, cessation treatment, colonoscopy). The next level is clinical interventions, which require not just one-time or a light touch from the clinical system, but a daily interaction (e.g., prescriptions for high blood pressure, high cholesterol, diabetes). This is followed by education and counseling (e.g., eat healthy, be physically active). Those at the bottom level will have the most impact, while those at the top will have the least impact. That is, being able to affect the context will promote health much more effectively than counseling people one-on-one not to smoke or to be physically active.

More than twice as many AI / ANs as whites do not complete high school, while 2.5 times as many AI / ANs as whites live below poverty level [CDC Health Disparities and Inequalities Report 2011, MMWR, Vo. 60]. AI / ANs have significantly higher morbidity and mortality rates in many areas: alcoholism: + 519%, tuberculosis: + 500%, diabetes: + 195%, unintentional injuries: + 149%, homicide: + 92%, suicide: + 72% [Indian Health Services, 2003-2005 rates]. Data from the *CDC Health Disparities and Inequity Report—United States, 2011* showed that AI / ANs are almost three times as likely as whites to lack health insurance (34% versus 15%); from 2002–2008, colorectal cancer screening increased by 4 percentage points among AI / ANs versus 11 percentage points among whites and blacks; infant mortality rates were 48% higher for AI / AN women versus white women; and AI / ANs have the second highest unadjusted homicide rates (8/100,000 versus 3 for whites and 23 for blacks).

The suicide rate among AI / AN is more than twice that of blacks. Suicide is the 4th leading cause of years of potential life lost (7.5% of all YPLL). Multiple factors account for this, including individual-level factors (e.g., alcohol, drugs, mental illness), family or peer-level factors (e.g., family disruption, suicidal behavior of others), and societal-level factors (poverty, unemployment, discrimination, broader issues). Dr. Frieden lamented that tragically, AI / AN teens and young adults have the highest suicide rates, which he said breaks his heart [CDC Health Disparities and Inequalities Report 2011, MMWR, Vo. 60].

AI / ANs have by far the highest rate of commercial tobacco use. AI / AN adults and youth aged 12-17 have the highest smoking prevalence of any group (42% of adults smoke; 17% of youth smoke). They had sharpest declines in smoking trends from 2002–2003 to 2007–2008 [CDC Health Disparities and Inequalities Report 2011, MMWR, Vo. 60]. AI/AN adults are twice as likely as whites to be obese, with 2/3 of AI / ANs adults having unhealthy weight, 36% being overweight, and 33% being obese. AI / AN women are 40% more likely than white women to be obese, with more than half of AI / AN women being overweight [HHS, Office of Minority Health]. AI / ANs are more likely to be diagnosed with heart disease than whites. AI / AN adults are 1.4 times as likely as whites to be diagnosed with heart disease, and are 1.3 times as likely as whites to have high blood pressure [Indian Health Services; CDC, National Center for Health Statistics, 2005]. AI / AN teens had largest increase in birth rates from 2005–2007 [National Center for Health Statistics].

While the problems are serious, there are solutions. There have been winnable battles in tobacco through Tribal Support Centers (TSCs); development of culturally appropriate interventions; work with the National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN) and partners to expand surveillance systems and implement interventions and evaluations; work with NNCTAPN on a Racial and Ethnic Approaches to Community Health Across the US (REACH-US) initiative to integrate tobacco control with chronic disease programs in tribal health systems; and work with NNCTAPN and local governments to adopt no commercial tobacco policies and smoke-free work policies. Secondhand smoke kills just as smoking does. People who are exposed to secondhand smoke are more likely to have a host of problems, including premature births, cancer, heart disease, et cetera.

Eliminating exposure to secondhand smoke will not only protect non-smokers, but also will encourage smokers to quit. Smoke-free laws save lives and they do not harm business. The Institute of Medicine (IOM), which is the most objective and respected body in the US for scientific knowledge, recently reviewed studies from around the world on what happens to non-smokers when a community goes smoke-free. It is known that approximately 20% to 30% of those who work in a workplace that decides to go smoke-free will decide to quit smoking and stay quit. It also turns out that non-smokers' risk of a heart attack decreases by approximately 15% to 20% merely from not being exposed to others' smoke. Smoke-free laws save lives, do not hurt business, and are a great way to make more progress in tobacco reduction.

Dr. Frieden was working in India from 1996 to 2002. When 9-11 occurred, he began thinking about going back to New York City. He was born in New York City, was trained there, and worked there for many years before that. The attack made him feel that he should return to try to contribute to the recovery of the city. He had been highly engrossed and immersed in his work in his tobacco control in India for the previous five years, and had not been paying much attention to what was occurring in the US. When he downloaded the data for New York City, he was shocked at how dominant a cause of illness and death tobacco remained. When he was asked whether he was interested in working in New York City as the Commissioner, he said it depended upon whether Mayor Bloomberg was interested in taking on tobacco. The first step was for the mayor to raise taxes on tobacco by \$1.42 and it has been raised a couple of times since, such that a pack of cigarettes in New York City now costs about \$11.00. They then met with all of the leading tobacco experts from around the world to determine the most important thing that could be done. They recommended instituting smoke-free laws because these have such a major impact. Such laws save lives by protecting non-smokers; are a way to help smokers recognize that smoking kills not only themselves, but also people around them; and make it much less likely that people will smoke. It was an unexpected and massive battle to go smoke-free in New York City. Mayor Bloomberg would say, "If you want a character-building exercise, you should ban smoking in bars and then go on a march on St. Patrick's Day in Stanton Island," which is a conservative community where people were holding up signs with sayings such as, "I smoke and I vote."

Nevertheless, within a year or two no one would ever go back to the era of smoky workplaces. It is simply inconceivable, and when people visited other parts of the US or other parts of the world, they were shocked that they would be smoked on while eating, drinking, or in a workplace. This rapidly became the new normal. When New York City went smoke-free, the State of California was smoke-free and no other states or countries were. Today, most Americans are protected by smoke-free laws and about 20 countries have gone smoke-free. There has been a lot of progress. It is also important to deliver education to change the image of tobacco. As a doctor, Dr. Frieden thinks about the patients he cared for who had strokes at

an early age or who had to gasp for every breath. That is the result of commercial tobacco use, and that is what must be made clear, especially to youth.

Winnable battles in nutrition, physical activity, obesity, and food safety include REACH US, which funds 6 programs to address and eliminate health disparities in American Indian communities. This includes two Centers of Excellence in the Elimination of Health Disparities: 1) Oklahoma State Department of Public Health that does work in obesity, diabetes, and cardiovascular disease (CVD) among American Indians in Oklahoma; and 2) University of Colorado at Denver and Health Sciences Center that does work in diabetes and CVD in AI / ANs, working with the Special Diabetes Programs for Indians (SDPI). Sugar-sweetened beverages are the single leading contributor to obesity. In addition to getting less physical activity, people are consuming a lot more calories (e.g., 250 to 300 per day per person), which is enough to make a major difference. Of those calories, about 120 are from sugar-sweetened beverages (e.g., soda, energy drinks, vitamin water). Drinking zero calorie drinks is very important. The Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS) monitor nutritional status of low-income infants, children, and women in federally funded programs. The Well-Integrated Screening and Evaluation for Women across the Nation (WISEWOMAN) program addresses risk factors for heart disease, including obesity, with two programs serving ANs.

The Communities Putting Prevention to Work Program (CPPW) aims to reduce obesity, increase physical activity, improve nutrition, and decrease smoking. The Cherokee Nation in Oklahoma received CPPW funding which they are using to limit unhealthy food options in schools, implement a farm-to-school program, and work to increase physical education in schools. In addition, they will increase access to tobacco cessation services and support 100% smoke-free air policies. The Cherokee Nation was specifically funded to serve as a mentor for other tribal communities. This is important because many of the interventions for chronic disease prevention are policy intervention (e.g., promoting breastfeeding, ensuring that children receive healthy foods in schools and daycares, ensuring that children can walk or bicycle to school). While these efforts do not require on-going funding to run programs, they do require political commitment to establish such programs early on. The knowledge to do that will be different in different communities, but there will be important lessons to learn. Therefore, the Cherokee Nation has been funded to learn those lessons and serve as a resource for groups throughout Indian Country.

Several Montana reservations also received CPPW funding, including Ft. Belknap for physical activity in the Head Start program, Rocky Boy for physical activity in the Boys & Girls Club, and Flathead for physical activity and nutrition and an after school program. The Montana Tobacco Use Prevention Program (MTUPP) funds the seven Indian Nations in Montana and two urban Indian programs. Montana CPPW funds support activities that will encourage AI / AN commercial tobacco users to quit and prevent youth initiation by expanding proactive counseling, promoting a quitline, and increasing the placement of billboards and radio advertising. Cessation services really do work. Chances of succeeding quitting alone are about 5%. If a doctor or other health care worker (HCW) talks to someone for just 4 minutes with personalized advice, this will substantially increase the chances of quitting. Receiving 4 sessions of counseling over a month or more will further increase the chances. Use of nicotine patches, gum, and / or other medications can double to triple the chances of quitting. To address diabetes, the Native Diabetes Wellness Program (NDWP) funded 17 grantees in 2010. These funds were to support community use of traditional foods and sustainable ecological approaches to diabetes prevention and health promotion; and engage communities to identify and share messages about healthy traditional ways of eating and being active.

Public health tries to change normal to a new normal such that the new normal becomes breastfeeding for 6 months, walking or biking to school, regular physical activity, et cetera. This will lead to much healthier, more productive, and happier lives. Increasing physical activity is very important, not only for obesity prevention, but also for reduced risk of high blood pressure, diabetes, cancer, et cetera. Dr. Frieden calls physical activity “the wonder drug.” In fact, regular physical activity is as effective as anti-depressants at preventing and treating mild depression. As he thinks about the suicide rate in young people, he believes that many problems could be addressed by physical activities. Certainly, there are important cultural traditions of regular, vigorous physical activity in Indian Country. There are not a lot of examples of communities systematically increasing physical activity. There is an inertial force to want to sit in front of the television. It takes effort to get up and do something. Therefore, people need to do things that they enjoy or they will not keep doing them.

There are winnable battles in motor vehicle injuries as well. From 2004–2009, pilot programs were implemented in 4 tribal communities to prevent motor vehicle-related injury and death that included increased seat belt use, increased child safety seat use, and decreased alcohol-impaired driving. This really is a winnable battle, with significant progress during this 5-year period in increasing seatbelt use from 43% in 2005 to 75% in 2009. Again, this becomes the new normal. *Effective Strategies to Reduce Motor Vehicle Injuries among AI/ANs* (2010–2014) will help tribes develop evidence-based effective strategies in programs, taking into consideration the unique culture of AI / ANs.

Teen pregnancy is all too often the result of mother-to-child transmission of poverty. Winnable battles in teen pregnancy include a REACH program in the Northern Arapaho Tribe to increase the number of Northern Arapaho and Eastern Shoshone women who initiate early prenatal care and sustain it throughout their pregnancies. The South Dakota Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) Project is a population-based risk factor surveillance system that addresses the high rates of infant mortality.

Winnable battles in HIV include the National Native American AIDS Prevention Center (NNAAPC), which provides capacity-building assistance to HIV prevention planning groups, community-based organizations, health departments, and other HIV prevention stakeholders. The Indian Health Service National Sexually Transmitted Disease Program works to enhance collaboration in STD prevention and control in AI / ANs, while the HIV Prevention Education Program for Cherokee Nation to provide HIV prevention education to AI / AN youth in high schools. HIV prevention can be done and is effective. It is important to increase testing, address high risk behaviors, and focus on the areas where the problems are greatest.

In conclusion, Dr. Frieden emphasized that CDC’s goal is to improve the health of all populations and eliminate health disparities; ensure that AI / AN communities receive public health services that keep them safe and healthy; and collaborate with tribal governments to develop programs and activities that target the needs of AI / ANs. CDC looks forward to building on the collaboration that the agency has with tribal governments and nations to develop programs and activities that effectively address the needs of AI / ANs.

Discussion Points

- Ms. Hughes said she could testify to the success of cessation programs in AI / AN communities, as it was her three year, six month anniversary of quitting smoking. When she visits her physician assistant on the diabetic team, there is a constant reminder about

quitting smoking. She receives a reminder about every two months. She sees her primary physician at the clinic where she receives reminders about the positive effects of stopping smoking. Everyone who comes through their program is receiving this message, and they have over 2000 active cases in the diabetic clinic, so they are reaching a large number of people and getting the message out. They have a large population they are trying to serve. The challenge for tribes is obtaining the funding necessary to be able to provide services and continue programs, such as the smoking cessation program. They realize the current economic climate has been a challenge for everyone, including tribes. Tribes that are fortunate to have gaming have a source of revenue, but even those revenues have decreased. This also creates a "catch-22" for them because tribes also generate fairly substantial revenue for the general coffers through the sale of tobacco. On one hand they are telling people to stop, but on the other they need these funds to provide services. Their governor has been fairly aggressive about doing whatever he could to reduce smoking, so he created laws for a smoke-free environment in the State of Wisconsin. He also raised taxes to \$2.75 per pack to make smoking more costly. Although this is the first full cycle of smoke-free environments, unfortunately there have already been discussions with the new administration about reversing the regulation. There is community-wide support for battling smoking, but it remains unclear why Native Americans are so much more likely to be smokers than non-smokers. That is a generational issue that applies across the board in terms of health issues. For example, AI/ NA are no longer eating foods raised traditionally. As a member of the Iroquois Nation, her tribe's food sources are supposed to be corn, beans, and squash. Through the last four generations, they have moved away from this, but are now trying with various programs to re-educate youth about the traditional foods that are healthier for them. It is recognized that this is generational, and that discussion is going to have to occur repeatedly. Any reinforcement they could get from CDC in that respect would be very helpful. They saw some presentations the previous day about traditional foods and the resurrecting of that philosophy on reservations, and she expressed her hope that as the years go by, they begin to see true progress in all of these areas.

- Ms. Abramson thanked Dr. Frieden for spending time with them and listening to them. Based on his presentation, she was very pleased to see that he was beginning to understand them and their concerns and issues.
- Ms. Hughes pointed out that CDC is a very large organization. Though this was her third year attending the consultations, she felt like she was still learning. They feel that CDC is still an untapped resource for AI / AN communities. They know that collaborations are critical to meeting their needs back on the reservations. It is their goal to see increased collaborations with CDC and the Indian Health Service (IHS), Centers for Medicare and Medicaid (CMS), Veteran's Administration (VA), et cetera, as well as better use of funding resources through those collaborations.
- Dr. Frieden quipped that he had been with CDC for 14 years, and he was also still learning. With regard to collaborative efforts, he shared a story to illustrate improving the quality of health care in Indian Country. Early in the discovery of anti-tuberculosis medications, there was a major problem in the AI / AN population. A man named George Comstock, who passed away at the age of 92 in 2007, worked in Alaska in the 1950s where he ran what is to this day the most effective tuberculosis control program ever run. People were treated in very large numbers, and preventive treatment was given to huge proportions of the community that was infected. They showed a very rapid decline in tuberculosis disease. Other groups tried to work with different tribes, but did not have much success. Tuberculosis is not easy to treat, because medications must be taken for at least 18 months

(now 6 months). One of the first uses of community outreach workers in the US was in some of the tuberculosis control programs that Cornell University and others implemented. Today, the leading killer is CVD and it is important for people to take blood pressure medications, check their blood pressure, and keep their blood pressure under control. The first Tuesday of every month, CDC releases *Vital Signs*. The previous day's *Vital Signs* pertained to the control of blood pressure and cholesterol. Half of Americans who have high blood pressure do not have it under control and two-thirds of Americans with high cholesterol do not have it under control. There are systems that have been able to greatly improve control, and they have done that using EHRs and lay people to help make improvements. It is worth reviewing the programs that currently exist to determine how they can be made more effective. With the Patient Protection and Affordable Care Act (PPACA), there are opportunities for new programs. Even if a clinic with 2000 clients had one or two community-based health workers who know who has high blood pressure and high cholesterol and could visit them systematically, it would be very good. Kaiser Permanente is often cited as one of the best health systems in the country. Ten years ago they had a rate of blood pressure control of 35%. By putting focus on it and standardizing and improving their care, they have increased that to 85%, which shows that it is possible to make very big improvements in a relatively short period of time. Using community workers is one way to do that.

- Ms. Hughes noted that Oneida has over 13,000 active users in its clinic. Lack of revenue challenges them in terms of being able to expand many of the programs and services. It is critical to be able to conduct follow-up, even though they are prescribing the appropriate medications. Much is paid for through tribal revenues (e.g., education, elderly services, law enforcement, et cetera). Even though it seems that tribes are making a lot of money through gaming, these funds must cover many areas. Most states are operating at deficits, but tribes cannot operate with a deficit. This creates an additional burden in being able to meet challenges.
- Dr. Frieden emphasized that the evidence shows that smoke-free laws do not harm businesses in the short- or long-term, especially if there is a "level playing field." People are going to go out to drink, eat, and be outside. They may be surprised at first when they cannot smoke outside, but this rapidly becomes the new normal. When they were beginning to implement the program in New York City, he went to Boston, parts of which were smoke-free, to conduct some research by going from bar to bar to speak with bartenders. Most of the bartenders were so young they could not even imagine ever having worked there when smoking was permitted, with the exception of an older Irish gentleman who was very loquacious. Dr. Frieden did not explain why he wanted to know this information. The Irish gentleman said that at his bar, business changed when they went smoke-free in that they were serving more food than they were previously because nobody wanted to stay there very long. Even smokers did not want to stay there very long because it was so unpleasant. There was a slight difference in the clientele in that those who stopped in for a quick smoke and drink after work were not there, but that was counterbalanced by people who stayed longer and drank and ate more. There was an unfortunate exemption for one of the clubs in the area down the street, so he had lost that group. Even so, with the increase in people staying longer, he said did not hurt his business. When Dr. Frieden asked the Irish bartender whether he thought other places should go smoke-free, his response was that they absolutely should because everyone would be healthier and live longer. When asked if he ever smoked, the Irish bartender said, "No. Well, I've been tending bar for over 40 years, so I guess I did smoke a lot."

- Mr. Petherick acknowledged how fortunate the Cherokee Nation is to be one of the CPPW grantees. He said that if anyone was wondering why they had not yet been mentored, they have only been working on this effort for about nine months, so they are still trying to get all of their affairs in order. Internally, they have been having tough discussions about balancing economics and health care needs. They believe as they go through this process, they will have a lot of valuable information they can share with all of Indian Country. They have brought in representatives from the business side to have these tough conversations. He believes the CPPW has brought them together and has been a valuable tool to develop leadership within the Cherokee Nation. He believes this is at the heart of driving the policy changes that are necessary to have a healthier population. He inquired as to whether Dr. Frieden had any thoughts on how they could share that the message must come from the policy makers, from the elected tribal officials, to make changes. This is not about individual changes—it is about changing policies and the environment.
- Dr. Frieden responded that throughout the country and the work, real impact is observed when a good leader is empowered to do something effective. A few years ago, Mexico City went completely smoke-free. This was very unexpected and was done for various reasons, one of which was that the mayor really wanted to do this and they had a health commissioner who was very dynamic. Against all expectations and essentially overnight, they went smoke-free with close to 100% compliance. There are some leaders who are going to be willing to do things like this, and there are some who are not. If someone is willing, it is important to harness and channel their enthusiasm and commitment, and the right technical details are required with regard to what to do. Sometimes this can be done in ways that are not as controversial. About a year and a half ago, Arnold Schwarzenegger proposed about a half a dozen important laws in California to reduce obesity. These included improving nutrition in schools, improving physical activity in schools, et cetera. These were things that did not necessarily cost much or in some cases even any money, but can make a major difference. About 100 to 150 years ago, infectious diseases were the leading cause of death. People often saw those as results of individual sin or bad behavior. Then the germ theory of disease came to be understood with respect to unsafe water, food, poor nutrition, et cetera. The solution was not to council an individual to change. Instead, the solution was to change the environment in which they lived so that if people would just “go with the flow” they would not become ill. The same is true of non-communicable diseases. People live in an environment that encourages them to eat too much, drink too much, and smoke. Changing that environment will support personal responsibility and empower communities to help their residents live longer and healthier lives. Finding winnable battles, specific efforts leaders can make, and empowering them to make a difference is very important.
- CAPT Billie indicated that she is Navajo from the Utah portion of the Navajo Nation and that she has worked with CDC for about 18 months in the National Center for Injury Prevention and Control (NCIPC). She works with the four tribes that were funded to address motor vehicle injury prevention. Since she has been at CDC, she has really appreciated the support that they have received from NCIPC to fund these tribes. As Dr. Frieden mentioned, the four tribes that were funded were able to show great progress in not only increasing seatbelt use, but also in reducing motor vehicle injuries in their communities. When she came to NCIPC, four tribes were slated to be funded again. They requested that six tribes be funded, and were approved for eight, which is very exciting. Of these tribes, three are in South Dakota, two are in Arizona, one is Oklahoma, one in California, and one in Alaska. CAPT Billie expressed her appreciation for how CDC has been willing to expand its reach. While eight tribes may not seem like a lot out of 564, they soon planned to meet with three

other agencies in Washington, DC that are also trying to address motor vehicle injuries: Bureau of Indian Affairs (BIA), National Highway Traffic Safety Administration (NHTSA), and Indian Health Services (IHS). The program managers who will be meeting from those agencies have invited some tribes with whom they have worked who have had successes in motor vehicle crash injury prevention. CDC will be spearheading a best practices manual that tribes can use, regardless of whether they have their own police departments. This is very exciting, and CAPT Billie stressed that she wanted to express general appreciation for the support she feels she has received when she has spoken on behalf of tribes since she has been working at CDC.

- Dr. Frieden replied that this is a program CDC is very proud of and is delighted to partner on with tribal leaders. He has met with Administrative Strickland of NHTSA several times, and the issue of the high rate of injuries in Indian Country is high on his agenda to try to do more about. Dr. Frieden expressed his hope that CDC and NHTSA can engage in more efforts together. This is an area where major resources are probably not needed in the long-term. Instead, policies need to be changed and programs need to be implemented to change how people behave. He remembers that when he was growing up, hardly anyone used seatbelts. Now it is difficult for most people to imagine not using a seatbelt. The world is changing, and once the change is made, there is a new normal of a healthier place.
- Ms. Hughes pointed out that this illustrates the generational issue that she mentioned earlier. When her grandson gets in the car, the first thing he does is make sure everyone has on their seatbelts. He does not like for his mother or father to back out of the driveway until his seatbelt is on, and he makes his point very clear to them. However, she does not remember her parents ever using a seatbelt and she knows elders now who do not use them regardless of all of the discussions they have heard. The children are going to make the change.
- Ms. Abramson pointed out that another problem is that they often have 10 people squeezed into a car as well. She reported that just in via Blackberry from her daughter, who works for the Inner Tribal Council of Michigan, was a question regarding whether there will be additional funds to address data issues for tribal populations, for example, funding for the American Indian Adult Tobacco Survey (AI-ATS), which supports policy implementation for tribes.
- Dr. Frieden responded that money is a real problem, and that the times are unprecedented. He cannot predict what will occur in the future. Fiscal year 2011 is still operating under a Continuing Resolution, which would expire in a month. Congress will do something for some portion or the rest of the year. There are some members of Congress who would like to see large reductions in budgets. The proposal for the President was to increase funding overall, and there is a real commitment to addressing American Indian and Alaska Native issues. Also, the first priority of CDC is to improve information. This can be done in a variety of ways, including EHRs and getting more information from them. PPACA includes a Prevention and Public Health Fund that is allocated at \$750,000 million in this fiscal year and \$1 billion in the next fiscal year. President Obama will release his budget in the next couple of weeks and the proposals will be made public, which Dr. Frieden thinks is very positive in terms of being able to understand and address health problems. What ultimately occurs will be up to Congress. While he did not know the extent to which tribal groups interact with US elected representatives, in many of the locations where tribes have a large presence, like Montana, there are very influential Congressmen and Senators. CDC is very committed to increasing the availability and dissemination of information.

- Ms. Bohlen noted that one of the issues that is often raised by tribal leaders across the country is that of state and tribal relations and sovereignty. That has also been discussed many times in the CDC consultation sessions. A couple of weeks ago in the proposed regulations from Indian Health Services to instruct states on the implementation of the exchange programs, there was a suggestion that in the application process, states are required to indicate how they will consult with tribes and make certain that they have accountability for ensuring that tribes have access to finances, with the clear attention of the law that the money is meant to be shared with tribes that reside within those state borders. This is a promising move in the right direction for tribal / state relations accountability.
- Dr. Frieden replied that CDC has reviewed this model and has done this in some of its grant programs. In some of the grant programs, the agency is not permitted to do this legislatively. However, this is the type of effort CDC would like to see more of. In addition to this issue being addressed in the consultation session last January in Atlanta, CDC has facilitated some meetings between the Association of State and Territorial Health Officials (ASTHO) and some of CDC's groups to ensure that there is as good an interaction as there can be. He thanked everyone present for their interest and their commitment to health. There is a lot to do, but on a positive note that means a lot of progress can be made.

CDC/ATSDR Winnable Battles: Tobacco

Tribal Leader Presentations

Philene S. Herrera
Division of Health
Navajo Nation

Ms. Herrera reported that the Navajo Nation introduced a smoke-free initiative to the Tribal Council two times. Each time, the Council approved it. The initiative was presented to the standing committees prior to presenting the initiative to the full Council. Each of those standing committees (except the health committee) approved the initiative, including a condition that they would accept a smoke-free environment with the exception that casinos and gaming facilities would be exempt. The President vetoed it and wanted to ensure that casinos and gaming facilities still brought in smoking patrons. There is now a new administration in place, which they hope is smoke-free friendly. The smoke-free initiative will be reintroduced. The Tribal Council was reduced from 88 members to 24, so there will be significant changes. Funding to tribal organizations and other resources (e.g., technical assistance) are needed, given that this legislation will be an unfunded mandate.

There is a coalition in the Southwest part of the Navajo Nation through the Southwest Navajo Tobacco Prevention Network (SNTPN). The director there is Peter Nez, and this is a great coalition with Dr. Patricia Nez Henderson moving that along. There are not enough people to cover all Navajo communities with about 300,000 people in the Navajo Nation. There is great disparity in addressing the tobacco problem. The Navajo Nation conducts a Youth Risk Behavior Survey (YRBS). The most recent YRBS was in 2008, which indicated that 34% of the youth in the Navajo Nation are current tobacco users. Looking to the future, this will translate to higher health care costs. Navajo Nation needs expertise to help them address risk factors and provide information to their youth. They have attended training off of the reservations, but the

majority of funds are in the metropolitan areas. It would be nice for funds to be allocated to rural America.

Ms. Herrera said that working with the states is like “pushing rope” to bring their services to the Navajo Nation because they stop at the border. In Arizona, three counties border the Navajo Nation and they stop at the line. She expressed her hope that making states accountable would become an expedited activity for CDC. The Navajo Nation plans to target youth and needs support from CDC for social marketing methods. While she agrees that social marketing is for all populations, the campaigns must be crafted to have equipment and staffing. Tobacco companies invest considerable funding in their marketing campaigns, especially to minority people. Tobacco companies have been on native lands giving out free samples of tobacco products to native people. The Navajo Nation has only 5 code enforcement staff to cover the whole nation. It is very difficult to fight against the powerful tobacco companies.

Because of health care reform and decreasing funding for tertiary care and secondary care, the Navajo Nation engaged in a budget formulation exercise with IHS. The Navajo Nation ranked their priorities 1 through 10. One of the top 4 priorities identified was health promotion / health education. They believe that more funds need to be invested in prevention efforts in the hope that as frontline health educators, especially working with youth in comprehensive school health activities, could target youth through an evidence-based curricula that will be interactive, fun, discourage use, counter tobacco marketer’s messages, et cetera. They believe this will be an effective way to reach high risk areas and curb the initiation of first use of tobacco.

**David Nez, Coordinator
Public Health and Emergency Preparedness Response
Navajo Nation**

Mr. Nez indicated that Navajo Nation would be submitting a written report. Regarding their geographic area and structure within the states, the Navajo Nation has a very large land base in a very rural area. Therefore, they do not have state or county health care systems on the Navajo Nation, although their geographic area spans more than half of the counties in some locations. There may be county health systems situated at border towns, but they are not located where the density of the population is. IHS facilities are where the funds are allocated and workforces are located.

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

Ms. Hughes indicated that Oneida is fortunate in terms of the programs they have, including smoking cessation. For smoking cessation they have three professionals who were trained by the Mayo Clinic as Tobacco Treatment Specialists. Thus, they are able to provide assessments and counseling to individuals and groups. They are also able to provide a number of products that are available for cessation. It is still a great battle. Many tribes have difficulty acquiring any funding from states. Even if the local areas are receiving funding, tribes have difficulty accessing that funding also. Oneida’s programs are paid for primarily by the tribes, although they do receive some small amounts of outside revenue. She encouraged CDC to consider not increasing funding. There is a funding base for this program, so she would ask that CDC consider allocating a set-aside for tribes since they often cannot access funds through the states. Granted, this will create a challenge elsewhere, but it would helpful to have even a small percentage of the funds.

Oneida's greatest need is the educational component, starting with the school system. More educational materials are needed to encourage youth not to start smoking or to quit if they already are smoking. More information is also needed on commercial versus traditional tobacco usage. They have some materials, but they could also use videos and studies to provide factual information. They are trying to stop smoking in casinos. They have 3 large casino operations and 4 or 5 smaller facilities (e.g., 100 to 200 slot machines). The two smaller casinos were made smoke-free on a trial basis for a one-year period that will end July 2011, and they will be assessing this. As with the Navajo, it will be a great challenge to convince the leadership to consider an across-the-board smoking ban in casinos. The State of Wisconsin is smoke-free, which the Oneida Tribe honors with the exception of its casinos. Those revenues mean a lot to the coffers of the tribes. There is a general belief that business will drop if casinos are made smoke-free. Ms. Hughes personally agrees with Dr. Frieden that there will not be that significant of an impact.

Ms. Hughes also pointed out that the insurance industry is another avenue for funding smoking cessation programs; however, many insurance programs do not allow for coverage of such programs. Oneida has a self-funded program that will pay for CHANTIX. However, it does not cover counseling or in-patient treatment. She wondered whether CDC could be instrumental in encouraging the insurance industry over all to cover more of the costs for cessation programs.

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

Most tribes experience double the prevalence rates of the US general population. They are, therefore, burdened by a higher prevalence of chronic diseases associated with commercial tobacco abuse. Tribes benefit greatly from the Tribal Support Centers and the National Networks, and would appreciate the support of these initiatives by the OSH staff. These types of efforts directed for tribal communities to implement programs at the tribal level are an important component in efforts to develop policy at the tribal level to decrease the prevalence rates of smoking in tribal communities. Currently, there are six or seven Tribal Support Centers. It would be highly effective for more Tribal Support Centers to be funded. In addition, the infrastructure for tribal tobacco programs needs to continue to be supported and enhanced with funds from CDC just as they are funded for states. This will also support policy development and implementation. Continued support for the implementation of the American Indian Adult Tobacco Survey needs to be enhanced and continued. This survey has been a key driving factor in the development of tobacco policies at the tribal level. It provided tribes with tribal-specific data and is collected *by* and *for* the tribal community. Ms. Abramson said she was probably one of the lone individuals among the Saulte Ste. Marie Chippewa Indians council who would like for their casinos to become smoke-free. She has raised the issue of the dangers of secondhand smoke and economic impact a number of times, but did not have anything to back this up.

Brenda Neilson
Quileute Tribe
Executive Secretary, NPAIHB

Brenda Nielson reported that the Northwest Portland Area Indian Health Board (NPAIHB) now has 43 tribes, most of which are very small tribes with user populations under 500. Recently, the Northwest Tribal Epidemiology Center (NWTEC) conducted a survey of various public

health actions pertaining to tobacco. Most tribal leaders are interested in help providing pharmaceutical assistance to help people quit smoking. This is a major struggle. The economy is very poor across the nation. On some of the smaller Northwest reservations, access is a tremendous burden. Approximately 47 of the health leaders interested in developing a new tobacco policy, and 40% felt that quit smoking media campaigns are needed for tribes to educate youth. With respect to the spotty record of state support for tribal entities, there is limited assistance, especially in the smaller areas. Often, the assistance is based on user populations. She is with the Quileute Tribe, which receives little funding from the state or county. It is barely enough to access some of the education materials that are available. They often start a program, but the funds quickly dissolve and they can no longer move forward with a program / education. The Portland Area Indian Health Board (PAIHB) has been great in terms of providing back-up assistance within the health arena; however, like everywhere else the support is very limited. It feels like they touch an individual and then have to stop because of funding issues.

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

Mr. Finkbonner noted that Dr. McAfee's absence from the Northwest is felt, and he thanked him for continuing to work on tobacco smoking efforts. Washington State had a good system; however, it was under-resourced in terms of working with the tribes. The smoking program representatives reached out to tribes to try to make the program work. He thinks there should be general, statewide media campaigns as well as culturally specific campaigns. However, it seemed to him that the media campaign did not seem to be targeted to the demographic it needed to address. This could have to do with the pricing structure of media venues versus any specific strategy. He is not a smoker and is older so perhaps he misinterpreted this, but his nieces and nephews would never watch the same things he is, so they would not likely be reached. He found that to make the greatest difference in his tribe in terms of policy making, they must begin by educating the elders and convincing them about the health benefits of an activity. Once their support is obtained, they will put community pressure on others to change. Whenever they can, tribes embrace their elders to become change agents for their communities. Another effort that works well is to disseminate information about model tribes that have effectively implemented programs and have demonstrated success, including information about how they created an environment for change. The Puyallup Tribal Health Authority (PTHA) has a model program that follows the cessation program to the letter. It is a matter of getting people who have been structured and diligent about implementing programs to talk to others about the obstacles they faced and how they overcame them.

**J.T. Petherick
Health Legislative Officer
Cherokee Nation**

In terms of the discussions about winnable battles and casinos, Mr. Petherick emphasized that they must not lose sight of all of the other issues they could tackle. From a health perspective, the Cherokee Nation wants to be out of the tobacco business entirely. However, this is going to take time—but, they do not know how much time. Simultaneously, they are trying to determine some of the efforts they can make immediately. The Cherokee Nation is very proud of implementing a tobacco-free policy government-wide. This is a start and they are trying to focus on what this means to them as a government and the areas they can address. They have assessed the efforts they can make to protect their children. He has recently been learning about third-hand smoke, which is a new concept, and thinking about how they can start

addressing this also. Their partners at CDC have been great at understanding and exercising patience with respect to how much time it may take within tribal governments to make such changes, and realizing that it is not going to happen overnight. They have also been working with advocates internally to ensure that they have the resources and supports they need to make changes within tribal nations in a way that recognizes the government-to-government relationship and the sovereignty of each tribal nation.

CDC Responses

**Dr. Tim McAfee, Director
Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Dr. McAfee emphasized that he is personally committed to working over the next year with his staff to try to elevate the issue of more aggressively reducing the prevalence of tobacco use in AI / AN populations. OSH would like to figure out how to do more, but funding is a problem. This is a statistic that Dr. Frieden showed to reflect the reality of many thousands of people who are suffering unnecessarily, and inaction should not be tolerated. The complexity of the situation is not a reason to sit back and do nothing. There are two other possibilities. In terms of CDC's relations with states, historically the agency has provided to states only about one-seventh of the money being allocated to tobacco control. It is almost 10:1. The states were allocating \$700 million and CDC was allocating \$70 to \$80 million to states. CDC's budget has remained about the same, but over the last three years the states have had a partial collapse and are spending about 30% less. Thus, state tobacco control funding is at the level it was in 1999. Every indication is that the next several months will bring more of the same.

Although states are raising tobacco taxes, they are lowering how much they are spending on tobacco control. Dr. McAfee said he brought this to everyone's attention because although it differs from state-to-state how much states are supporting tribal efforts, states certainly should be providing more resources than they are. Decisions may be made over the next several months at the state level that will be similar to what Dr. Frieden described at the federal level. Logically, if taxes are being raised on a group that is addicted, more should be spent on control. Unfortunately, that is not what is occurring. Another possibility is if tribes are receiving revenue from the sale of tobacco products, they should work with tribal leadership the same way that CDC is going to struggle with the states. CDC is trying to stress to states that if they are receiving hundreds of millions from the sale of tobacco products, which they are, even in hard economic times they should be using some of those funds to help youth and adults who are addicted. The advantage would be that tribes would have the opportunity to exercise more control over their destiny in the sense that if they are receiving funds from the sale of tobacco products, they could self-finance some of these activities that are very difficult to support through general funds. Dr. McAfee assured everyone that he would fight to try to get more revenue and technical assistance needed in Indian Country.

Dr. McAfee acknowledged that the work with casinos is very important and very challenging for many reasons. This is a problem for tribal casinos, as well as casinos in general. He applauded the fact that tribes are working on this issue, and OSH would like to assess other ways to support these efforts. Historically, OSH has had the capacity to provide letters of expert testimony on the dangers of secondhand smoke and the lack of an economic impact. They are also working on two efforts, one of which is to create tailored economic analyses to show that certain types of secondhand smoke activities will not result in economic harm. The other is a

video that will focus on the hospitality industry, including casinos, which will address the benefits to workers, employers, and users of the system.

With respect to state funding / support accountability, Dr. McAfee reported that Washington State receives three-quarters of a billion dollars from the sale of tobacco products. As they have increased the tax, they have steadily decreased the funding for the tobacco program from \$26 million per year down to \$14 million per year down to \$7 million per year. This year, they will either decrease that to \$4 million or zero. Dr. McAfee personally views this as essentially a scandal and a moral vacuum. This makes tribes' jobs much harder because they do not have funding for specific programs that tailor communications strategies to cultural specificity, and also because some states are abdicating their responsibility for general population messaging around mass media that really helps all people regardless of class, race, ethnicity, et cetera. It is known that the type of mass media campaigns that California has continued to implement despite economic hard times has an incredibly powerful effect that cuts across groups. Both are needed (e.g., cultural specificity and background programs). OSH is going to try to help fill the void over the next year and a half by implementing a major national media campaign. Unfortunately, they will not have the capacity to tailor messaging because this will be a national campaign.

In terms of insurance companies not covering cessation programs, it is ridiculous that they will pay \$30,000 for a coronary artery by-pass procedure or \$225,000 for a lung transplant, but will not pay \$200 to provide a cessation program. As Dr. Frieden pointed out, there are very effective programs that can double or triple people's chances of success. It should not be his job or tribes' jobs to pay for individual level programs. Those should be policy changes that are instituted with respect to Medicare, Medicaid, veteran programs, et cetera. The PPACA legislation includes provisions that would require private insurers to cover both medications and counseling that will be eased in over time between now and 2014 if PPACA continues to be implemented. There is a lot of "devil in the details" with respect to what will actually be covered and how that will work that really needs input from people who are going to be directly affected. It continues to be a burden to have to use precious resource dollars out of public health or clinical services for something that should be covered by insurance.

Regarding difficulties in convincing tribal leaders to institute smoke-free policies, Dr. McAfee explained that CDC could provide a formal statement for tribal councils regarding smoke-free policies, economic impact, and secondhand smoke. Tribes would have to make a formal request for this. In some cases they may not be able to do so, but in cases where an issue may come to a vote, they can provide technical letters of evidence. They know the three or four things that seem to work cross-culturally and internationally, such as help lines. Dr. McAfee re-emphasized the sense of urgency OSH is feeling and wants to convey in terms of trying to garner more funding to support activities such as social marketing. OSH staff would appreciate knowing if they are missing something. For example, should more emphasis be placed on winning over leadership and elders in tribes as source of change?

Dr. Kevin Collins
Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Collins said he was aware of the presentation from CDC's Financial Management Office (FMO) the previous two days regarding the resources that are dedicated to AI / AN through the Office on Smoking and Health (OHS). They know these resources are not sufficient. It is great

to see the support of the CDC leadership from Dr. Frieden and Dr. McAfee. OHS hopes to expand the efforts in Tribal Support Centers and National Networks, as well as in their relationships with partners such as IHS. They can do a great deal more by nurturing the IHS partnership to expand the range of services for those who are using tobacco through community policies and clinical services. There are many resources in the Tribal Support Centers and National Networks as well. OSH works closely with the state tobacco programs to try to increase their capacity to offer services and technical assistance throughout the states, as well as national partners such as Campaign for Tobacco Free Kids, American's for Non-Smokers Rights, and other national organizations to better address tribal needs in this area. Dr. Collins also reported that there are a number of resources available. That is one of the goals of the National Networks. There is an American Native National Network, the National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN). They can be found at: www.tobaccopreventionnetworks.org where there is a link directly to the NNCTAPN network: http://www.tobaccopreventionnetworks.org/site/c.ksJPKXPFJpH/b.2588443/k.4B5C/NTTPN_American_IndianAlaska_Native.htm Many resources can be found there such as pamphlets, links to other professionals with experience working in the community, et cetera. Even in small, remote areas there are ways to get resources to tribes very easily.

Dr. Bridgette Garrett
Office on Smoking and Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Garrett said she was surprised to find out that 34% of youth are smoking, and that the report that Dr. Frieden presented showed that about 18% of AI / AN youth are smoking. That is a huge difference in what the national data show. It is very important to present a more accurate picture of the smoking prevalence rate in youth. She assured everyone that they would take this information back to their office to discuss how they can do a better job of reporting. While Dr. Garrett was not sure what type of barriers or challenges they would have in terms of getting funds allocated for tribal needs, they do have a deadline with regard to disparities as a national tobacco control goal that every state is supposed to address. This includes working with tribes. She acknowledged that the agency needed to do a better job of holding states accountable to address those disparity goals and to allocate funds accordingly. That is how it is supposed to be working currently. Dr. Garrett agreed that counter marketing is critical. There has been a history of predatory marketing by the tobacco industry to the minority community, including AI / AN communities. OSH recently submitted a small business research proposal to develop culturally tailored tribal anti-tobacco messages; however, it was not funded. They will continue to seek additional funding for those types of initiatives.

Dr. Wayne Giles, Director
Division of Adult and Community Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Giles pointed out that the Division of Adult and Community Health (DACH) has a slightly different perspective. As opposed to being content experts, DACH allocates a lot of funding to local health departments, community-based organizations (CBOs), and tribes. DACH has a number of community programs, including REACH. REACH is focused specifically on addressing issues pertaining to health equity in communities throughout the country. The Centers of Excellence for the Elimination of Disparities (CEEDS) were created under the REACH program. Tribes that have been particularly effective in disparity elimination have been

funded to teach others to eliminate disparities as well. In 2012 there will be a re-competition for REACH CEEDS and other communities as well. Having tribes help get the word out about this opportunity will be vitally important to ensure that some good tribes are included in the mix so that they can highlight and further disseminate the information.

They have another program titled Action Communities for Health, Innovation, and EnVironmental change (ACHIEVE), which focuses on building capacity with respect to policies, systems, and environmental change strategies. Through ACHIEVE, funding opportunity announcements (FOAs) are disseminated through several national organizations on an annual basis, including the National Association of Chronic Disease Directors (NACDD), National Association of County and City Health Officials (NACCHO), National Recreation and Park Association (NRPA), and the YMCA of the USA (Y-USA), to build capacity around policies, systems, and environmental change strategies. DACH would love for more tribal communities to apply for ACHIEVE funding. Additional information is available from the Healthy Communities website located at:

<http://www.cdc.gov/healthycommunitiesprogram/communities/achieve/index.htm>.

Most recently, CPPW is funding 50 communities across the country to engage in policy, systems, and environmental change work in obesity and / or tobacco prevention. Cherokee Nation of Oklahoma and the Great Lakes Inter-Tribal Council are funded as part of this initiative. Both of those communities are working on tobacco issues, particularly in casinos. There could be opportunities for some peer-to-peer networking in terms of what those tribes have been able to achieve. Establishing linkages between CPPW communities and tribes would be a useful effort, and DACH can try to facilitate this.

CDC/ATSDR Winnable Battles: Obesity, Nutrition, Physical Activity, Food Safety

Tribal Leader Presentations

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

Ms. Abramson pointed out that AI / AN adults are 2.3 times more likely than white adults to receive a diagnosis of diabetes, and 1.6 times as likely as white adults to be obese. In order to address these health disparities, tribal communities need to be able to seek better health; help change local health care practices; and be better mobilized to implement evidence-based public health programs that address their unique social, historic, economic, and cultural differences. The REACH-US program has been highly successful in empowering tribal communities to significantly reduce their health risks and manage chronic disease. Providing tribes with the ability to create infrastructure to implement comprehensive programs with evidence-based tools has been highly successful and well-received by tribes. It is important to support programs that allow tribes to adapt to their unique tribal community environment. On-going funding and support for REACH and similar programs for tribes need to be continued and expanded. The REACH project has allowed tribes to recognize and invest in local community expertise. Opportunities to enhance the availability of tribal-specific health risk data need to be supported and funded. This information has been highly useful for tribal communities that have fielded

tribal-specific Behavioral Risk Factor Surveillance System (BRFSS) survey. Policy needs to be developed, supported, and funded for on-going tribal-specific health surveillance.

The Saulte Ste. Marie Chippewa Indians are way up north in Michigan, and they are woodland and rural. They know what to do. While CDC is interested in scientific data collection, the things that need to be done are things that they have grown up with. This gets back to their way of life. It really was not that long ago, but it was interrupted. With that, slowly but surely their lifestyles changed because of the land and being crowded into areas that were not as free to roam and live their lives as they had been. Living the way they once did kept them healthy, except for some of the diseases that came along with the other things that came along. The traditional foods program is the nucleus of what can happen. They are trying to resurrect gathering, hunting, and fishing in an effort to get families back to getting physical exercise. Mothers, fathers, sons, and daughters are spending family time together learning how to catch and prepare fresh fish, deer, rabbit, and moose. One activity they had was sucker clubbing, which was fun and it was physical activity. They gather wild rice and they dance on it, which is a good aerobic exercise. It is quite the workout, plus the wild rice is good for them. They gather maple syrup, berries, and vegetables. It takes exercise to do that, and they can and preserve foods. These foods will be stored and are the good foods that they need to eat. Birch bark is gathered to make baskets and is among the plants that are medicinal. When they are out there gathering, they are among the medicines that make them feel good. They are listening to stories and learning their language as they go along, and they are keeping busy doing family activities, so they are not smoking. They want to see this brought back to the community more. There are many opportunities to do things the way they were, with the love and connectedness that goes into it. That is what makes healthier community and people. CDC can collect whatever scientific data they need, but traditional ways are what will make AI / AN populations healthier and CDC needs to empower them so that they can continue and get this back. It took a long time to get sick and it will take a while to get healthy again.

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

Ms. Hughes spoke about obesity and youth, noting that the First Lady has taken up this issue, which points out the significance of the problem. There is a disparity for tribes in this area as well. Oneida has been monitoring the situation and has found that 44% of their Head Start Students are obese. These are 3 and 4 year olds, and this is an absolutely outrageous number. She heard that number for the first time last year and could not believe that this was truly the statistic for their people. However, it is a fact and it is more important than ever to have the educational component to try to reverse what is occurring. The obesity issue is a major problem among tribes. The significance of that is that they are now diagnosing Type 2 diabetes in 12 years olds, which is extremely young. Programs such as the "Just Move It" program encourage physical activity and can be helpful. It would be beneficial for CDC to share information with tribes about programs that have been successful. The Eagle series has gone over very well, but tribes would like more toolkits.

She reminded everyone that the previous day, Commander Larry Alonzo presented on the introduction of traditional foods back into native lifestyles. For generations they all had certain sustenance foods on which they were raised. For Oneida these were corn, beans, and squash. It is no longer natural for their daily diets to be comprised of these traditional foods. Like everyone else, they have moved toward packaged, quick-produced, fast food items. It takes an educational process to return to traditional ways. They are attempting this in the school system

by having no sodas in vending machines. These contain water or juices. The classes are all encouraged to provide healthy snacks. Unfortunately, their reservation is located in five different school districts and they do not have the same cooperation from each school district. They are working with all districts to encourage them to at least use the healthy snack concept. Children eat at least one meal at school. All are getting lunch and morning and afternoon snacks. Some children may also eat breakfast at school. It is important to encourage the school systems in the US to support the Healthy Snack Initiative, which CDC and the First Lady have supported.

It is also important to promote the use of locally grown products. There are regulatory issues involved because the USDA has a say in what is served in schools, so they have run into some issues in trying to provide the Black Angus beef and buffalo that tribes raise. It is known that buffalo meat products are lower in cholesterol and fat and are a much healthier source of protein for children. It would be helpful if CDC could assist them in working with the USDA to change the regulations to allow a provision for more locally grown products in the system. Everything flows to diabetes (e.g., obesity, nutrition, physical activity).

Philene S. Herrera
Division of Health
Navajo Nation

Ms. Herrera indicated that she works for the Health Education, HIV, and Teen Pregnancy Prevention Program. Regarding obesity, they have their share of women who are of childbearing age who have diabetes / gestational diabetes, and they also have their share of overweight children. About half of their women are reported to have a body mass index (BMI) over the healthy range. They conducted a YRBS in 2008 that showed that 52% of their children were trying to lose weight, which is of great concern. Perhaps when they are in their 30s to 50s, these children will have chronic diseases. About a third of their children are overweight. The YRBS is a self-reported survey, so these are the children's perceptions of themselves. Of those responding, 30% did not exercise. There are numerous reasons for the lack of exercise (ditches, water, debris, roaming dogs, et cetera).

Tribes need assistance to make their environments more community-friendly, as well as assistance in writing grants to garner funding to do this. The diabetes program has been trying to make an impact by efforts such as creating a skateboard park. However, there are some children who live way out in the woods and beyond the forest. Those children have not been captured and they are not a part of this data. They need some strategies about how to tackle the hard to reach groups who are not in Head Start programs, not in schools or who have dropped out, and who are not in jails. As health educators, they design their health education presentations; however, that becomes a squeaky wheel after a while, so they would like to have fresh and different community presentations that are easy to obtain.

J.T. Petherick
Health Legislative Officer
Cherokee Nation

Mr. Petherick emphasized that in listening to some of the examples tribal folks had shared throughout the day, it is clear that many awesome efforts have taken place. There is an opportunity in which CDC staff members have access to the expertise as far as helping tribes build healthier environments, and to a lot of resources. The Cherokee Nation has benefited greatly from Mark Fenton visiting their communities to address issues that Navajo have such as

rural environments. He has a unique expertise and has really demonstrated his ability to understand tribes. Perhaps if others at CDC had a better understanding of tribes, CDC could be the bridge between tribes and subject matter experts (SMEs) to join everyone together. It would also be beneficial if CDC could provide resources as well so that SMEs and others can visit Indian Country to walk with community leaders. Being on the ground and talking to leadership is extremely valuable to communities. It is particularly helpful to inform tribal leadership about the opportunities they have to institute changes in behavior by changing policies and laws at the higher level to make it the easier choice for communities to implement programs.

Brenda Neilson
Quileute Tribe
Executive Secretary, NPAIHB

Ms. Neilson noted that many reservations do not have sidewalks or street lights. Those two items would be very helpful for young children. For example, having sidewalks would allow children to walk as opposed to riding in the back of a truck from place to place.

Joe Finkbonner, Executive Director
Northwest Portland Area Indian Health Board

Regarding cross-agency collaboration, Mr. Finkbonner reported that he remembered as a health director and general manager for his tribe there were running, heated discussions with the US Department of Housing and Urban Development (HUD) about what was allowable. Sidewalks, playground structures, and other such items were always key issues. It was beneficial in his area to have a public health department representative sitting in on the planning and public works permitting committee to raise these issues and help determine how to structure housing development in tribal country with health and safety in mind. He suggested having those conversations with HUD, the Department of the Interior (DOI), Bureau of Indian Affairs (BIA), Department of Justice (DOJ), et cetera this will go a long way to highlight this common issue.

CDC Responses

Dr. Ursula Bauer, Director
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Bauer indicated that through the CPPW initiative, they are developing strategies to get into communities, changing environments, supporting positive health behaviors, working to create farm-to-school programs, et cetera. CPPW is a two-year program that concludes midway through 2012. They are hoping to launch a new program that was authorized under the PPACA legislation, which is Community Transformation Grants. This is not necessarily the next generation of CPPW, but it applies many of the same principles in terms of working with communities, transforming the community environment to better support health, et cetera. If funds are appropriated for that program, they hope to be able to fund a wide range of programs across the country, including communities in Indian Country. The focus would be on addressing the core public health problems pertaining to nutrition, physical activity, tobacco, diabetes management / prevention, et cetera. The First Lady has recently launched a "Let's Move Indian Country" initiative, which is focused specifically on Native Americans. This is an effort to ensure that the "Let's Move" initiative is far-reaching in addressing parts of our population where there are some serious health problems like diabetes, obesity, nutrition, and physical activity. Rural /

isolated populations of children, adults, and families who are not connected to institutions or community resources are challenging across the board. While NCCDPHP does not have the solutions, they will work with tribes and partners in other rural areas to figure out to support healthy lifestyles among more disconnected populations.

In terms of resources for presentations, NCCDPHP can collect what they have and get them to the tribes. There is a new resource on CDC's website. For each of the six winnable battles, CDC has put together a set of resources that includes a PowerPoint presentation that can be customized, supporting materials, evidence-based research, et cetera. In addition, Sebelius asked NCCDPHP to assemble what has been learned from the REACH, CPPW, and other initiatives and to identify the easy to implement programs that communities can put in place that do not require a lot of resources. These are to be packaged and disseminated deeply across the country, across all communities. Collectively, and with all of the programs NCCDPHP has supported over the years, there is a nice toolkit of things that can be done as simple as putting water in vending machines that currently have sugared drinks or as complicated as infrastructure projects. There are already a lot of actionable tools and strategies that need to be better-packaged. They can also work to determine whether these tools can be customized for various populations and communities. They need to do a better job of disseminating this information regardless of whether they have resources, given that much of this can be done in the absence of large resources.

Under PPACA, there is a provision for the creation of the National Prevention Council and the National Prevention Strategy. That council is made up of the secretaries from HUD, DOJ, USDA, HHS, DoD, et cetera. There are 17 cabinet members, and they are charged to assess their scopes of responsibility to determine how they can enhance health and prevention within their regulations / programs. All of these agencies are asking themselves this question. In the meantime, with the CPPW initiative, NCCDPHP is trying to get their usual health partners to think across sectors (e.g., transportation, housing, et cetera) when undertaking community health planning. Often health dollars come with restrictions about paying for physical infrastructure, for example. NCCDPHP is not able to build sidewalks or purchase playground equipment with its dollars. However, they can work with their grantees to determine how they can reach out to foundations or other funding sources to ensure that those resources get where they are needed.

Many words are being used these days that are very popular like *grass fed*, *free range*, *organic*, and *local foods*. Those seem to be new ideas that are popular, but they harken back to a time when people actually valued and ate the food they produced. People also valued the way they worked together as families and communities to produce that food. All populations across the entire US seem to have lost touch with the way our food is produced, and no one seems to value food. Everyone can just go into a store and pick a package off of the shelf, but it is not very healthy and it is not very expensive compared to how food used to be acquired. These changes in the way of thinking in terms of these words being used and changes in the culture are in some sense led by changes in Indian Country about assessing what our lifestyles used to be and thinking about how to get back to them. This is positive for the whole country, so consideration must be given to how to strengthen and reinforce that movement to nourish ourselves with healthful foods that we are producing and we are finding value in that activity.

**Dr. Wayne Giles, Director
Division of Adult and Community Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Dr. Giles further discussed the REACH and CPPW initiatives, which have been particularly impactful. Through the REACH, DACH has been able to fund a number of tribes across the country and has seen some very impressive results. The Eastern Band of Cherokee and the Cherokee Nation now have over 10 years of experience. Those two communities are focused on obesity, cardiovascular disease, and diabetes and are achieving some impressive results in terms of increases in physical activity, fruit and vegetable consumption, et cetera. As mentioned earlier, it is imperative to do a better job of making sure that those successes are translated to other tribal communities so that others can learn from what those communities have been able to do extremely well. There is also a REACH Risk Factor Survey that provides local community data so that the communities that are funded have their own local data. That is extremely powerful. The most recent community initiative is CPPW. Some of the CPPW communities are focused on tobacco, some on obesity, and some on both. One community is the Pueblo of Jemez in New Mexico, which is focused on obesity. This is a community on a reservation that is very rural. They are focusing on issues pertaining to gaining greater access to food. DACH expects to learn a lot over the next year to year and a half regarding effective strategies in this area. Being able to translate that to other communities will be important, particularly as they move forward to the Community Transformation Grants that Dr. Bauer mentioned. On the local level, NCCDPHP often brings together a coalition or team. One of the things Mark Fenton will often ask communities is, "Where is your city engineer or planner?" They frequently see that people do not think about others like that.

Ms. Alicia Hunter

**Division of Nutrition, Physical Activity, and Obesity
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Ms. Hunter acknowledged the need for enhanced collaboration between health departments, tribal governments, state education departments, and state agricultural departments. NCCDPHP can try to facilitate some of this work in partnership with tribal leaders. NCCDPHP agrees and is seeing the need for greater collaboration at all levels, horizontal and vertical, within jurisdictions. In some of NCCDPHP's planning efforts, they are trying to ensure that they have representatives at the table. She invited everyone to let her know if they would like to be a part of the Weight of the Nation Conference planning activities in which problems and solutions for obesity will be addressed at the national level and within different jurisdictions to include the tribal government and tribal land. When they last convened this conference in 2009, several tribes were represented. The Navajo Nation received one of the awards. Having tribal representatives at the table will help inform the conference to set a national agenda and will help to facilitate relationships with other public health practitioners who will be at the table.

Through the Division of Adolescent and School Health (DASH) which is in the center, CDC and the USDA have a document titled "Making it Happen in School Nutrition." While that and other documents were not necessarily developed for tribal governments, and Ms. Hunter recognized this as a deficiency, they can discuss how to translate those materials into useful documents for other populations. Obtaining tribal input on such documents would also be helpful. In terms of resources available, in addition to what Dr. Bauer mentioned, there is also a local government PowerPoint for nutrition, physical activity, and obesity. It is available on the website, and because it is a very large file, it is also available on CD-Rom or DVD and can be mailed. This gives you all of the information needed to present the case for school-, community- and workplace-based nutrition and physical activity efforts, and allow for input of a group's own data.

Regarding the popular terms being used that were mentioned (*grass fed, free range, organic, and local foods*), Ms. Hunter noted that one thing they often say at CDC is “health in all policies.” She saw a need for tribes to be involved in some federal policies like the Farm Bill, the Child Nutrition Act, et cetera. Thought should be given to how there can be greater discourse and engagement on some of the federal policies through a CDC-brokered bridge or through some other forum, given that these can have a major impact communities and what they can do to achieve connectedness and historically healthy behaviors that were once done out of necessity.

CAPT Nancy Williams
Division of Nutrition, Physical Activity, and Obesity
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

CAPT Williams acknowledged that there are numerous success stories, and that they do not get these collected and published as quickly as they would like. She has worked with the STEPS program and the tribes in Michigan, and there were great things going on. They simply need to gather all of these stories and ensure that there is a way to share them with other tribal programs so that there is availability of this information. She thought they could all do a better job of making this happen.

CDC/ATSDR Winnable Battles: Teen Pregnancy

Tribal Leader Presentations

Philene S. Herrera
Division of Health
Navajo Nation

Ms. Herrera reminded everyone that she works for the Teen Pregnancy, HIV, and Health Education Program for the Navajo Nation. They have a voter proposition funding for the State of Arizona for teen pregnancy prevention. They are working on the Western side of the Navajo Nation to prevent teen pregnancy. They have some data from a Pregnancy Risk Assessment Monitoring System (PRAMS) survey conducted by the Navajo Epidemiology Center. This was conducted only for the New Mexico side of the reservation that covers two counties (e.g., McKinley and San Juan). Some of the findings were that 65% of the women in these areas did not use contraceptives at the time of conception, 20% said their family did not have enough to eat in the previous 12 months, 16% reported alcohol use 3 months before pregnancy, and 5% reported alcohol use during the last trimester of pregnancy. Those are some startling data.

For Navajo, it appears that a lot of burden is on the female. She would like to know what type of resources CDC could share about male responsibility. It would be beneficial if tribes could be involved in curricula development to address these issues. She recognized that tribes differ from one another, so one curriculum may not be sufficient for all tribes; however, perhaps they could develop a way to share success stories. They want to tap into that information and share it like a talking circle. Perhaps a website could be developed for this purpose. They have one or two family counselors based in the clinics in the Navajo Nation, but they share their time with the community as well. Navajo Nation has 8 service centers / hospitals. These are located in the IHS service unit area centers across the Navajo Nation. Just having 16 total family

counselors to reach an approximate population of 300,000 people is not sufficient. She would like to learn from CDC how the Navajo Nation can continue to dialogue and how CDC can share resources that they can take back to Indian Country to share with tribal leaders and other CBOs. The family planning group is based out of Region 9 of San Francisco, and they are a separate entity in the Navajo Nation government, which is why they have CBO recognition. A survey for young men would be beneficial to help understand how males' thinking affects the risk of teen pregnancy. It seems that surveys are always about the burden on females, and that females are the ones always coming in for services to care for their children. The PRAMS survey also revealed that 71% of pregnant women are using WIC services. Where are the other 29%?

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

Ms. Hughes indicated that Oneida has some major issues pertaining to teen pregnancy. First, and most important, is getting pregnant teens in for proper care during the first trimester. They are currently presenting in the second and third trimesters, which is extremely late. The concern with this is that they may not have had good nutritional values prior to their pregnancy. There also could be drug and alcohol use involved. Conditions are very serious, especially in the initial stages of pregnancy. One reason they believe they cannot convince pregnant teens to come in early is because they do not want to identify the father. If they identify the father, they will be required to go to the state for Medicaid, child support, et cetera. Another reason is transportation. They do not want to tell their parents and they do not have easy back up for the transportation requirements for regular check-ups. Therefore, they keep putting off care until it becomes absolutely necessary or the parents find out about the pregnancy. Ms. Hughes thinks they need to change the educational materials to address those problems head on and provide encouragement and incentives for them to seek care, discussing the negative outcomes that could occur if they do not obtain prenatal care early. The educational materials are good, but do not address the true problems that are preventing pregnant teens from obtaining care. Her suggestion was for CDC to put a little twist on the educational materials they are developing.

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

Ms. Abramson stressed that Native American and Alaska Native teens experience significant disparities in a number of health status indicators (e.g., perinatal outcomes, substance abuse, education attainment, and exposure to violence). These factors place their children at risk of living in poverty, as well as encountering health-, developmental-, social-, emotional-, and behavior-related problems. There needs to be increased support and / or institutionalization of programs like the Healthy Start program that tribes can receive funding for in order to develop programs to meet the needs of their communities. It is known that for tribal communities, regular prenatal care does not ensure acceptable outcomes for mothers and infants, especially teen mothers. Increased support for infants, post-partum outreach, and inter-conception outreach have proven to be effective in decreasing death rates for American Indian tribes. Tribes need funding and support to institutionalize programs like Healthy Start that provide support services for infants, mothers, and teen mothers. In addition, there is a serious problem with racial misclassification on birth and death records of American Indian infants. It is known that 30% to 40% of deaths are missed because infants are reported as white or another race. There are effective methods to address this problem. Some tribes have partnered with states to

link tribal data and birth and death records to identify and more effectively report actual birth and death records for American Indian infants. This method needs more support and funding and needs to be acknowledged in an official publication about how severe this problem is.

CDC Responses

**Dr. Ursula Bauer, Director
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Dr. Bauer said part of what she was hearing regarding teen pregnancy and teen pregnancy prevention was that they really need to bundle that conversation with maternal and infant health, and think about the continuum of care. It is not just about preventing the teen pregnancy, but is also about ensuring that all mothers across the age span are receiving the care they need, and that there is support in communities for mothers and infants.

**Ms. Alison Spitz
Division of Reproductive Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

Ms. Spitz agreed with Ms. Herrera that the results from the Navajo Nation PRAMS survey were startling and upsetting. The Division of Reproductive Health (DRH) does want to work with them to determine what to do. DRH is working on an analysis with IHS, which has resulted in a paper titled, "Trends, Geographic Variation, and Correlates of Teen Childbearing among American Indians and Alaska Natives." They plan to submit this unique paper to the *American Journal of Public Health (AJPH)*. The paper shows the wide variation across IHS regions and how some have relatively low rates and some, like Aberdeen, have extremely high rates of teenage pregnancy; as well as the trends over time. It is her guess that this will stimulate a lot of conversation on this issue. It would be beneficial for CAPT Tucker and the other authors of the paper to talk to tribal leaders about how this paper might be used to help tribal nations in terms of the best way to disseminate the data, how it might be most useful, and what the follow-up efforts should be.

CDC funds various national organizations that are working on teen pregnancy interventions. She would like to go back to them to find out what specific work they may have done with tribal nations. Though she was not immediately aware of work with males or specific evidence-based curricula, she indicated that she would look into these areas. Over the past year, the HHS Office of Adolescent Health and CDC have listed 28 evidence-based sex education curricula that cover a wide range of populations. DRH at CDC has developed generic and curricula-specific adaptation guidelines for some of the most popular programs, so that might be something to consider as well in terms of whether one of those curriculums might be adapted to meet tribal needs.

**CAPT Myra Tucker
Division of Reproductive Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention**

CAPT Tucker indicated that she was present as the Tribal Liaison for DRH. While she could not address the specific needs that Ms. Herrera raised and she agreed with Ms. Spitz that these issues must be specifically addressed, she was able to speak briefly about PRAMS. She reminded everyone that earlier that morning Chairman Hughes mentioned that CDC is an untapped resource for tribes. She thought everyone would agree that in terms of potential support for tribes, CDC has barely scratched the surface. They recognize that funding programs and direct funding to tribes are essential elements of working together. In the meantime, one of the ways she thought they could be supportive is by providing information that can be trusted and shared. The DHR can work to ensure that its surveillance and data systems provide information about the stories of American Indian and Alaska Native women and children. The Navajo Nation example is a great illustration of getting the data to speak. The data can serve them well in telling the story and attracting resources. She mentioned during the Montana meeting last summer that PRAMS has programs in 35 states. In 10 of these states, 5% or more of the births are to American Indian or Alaska Native. Historically, response rates among American Indian and Alaska Native women have been quite low. There are only a couple of states in which the response rates have reached a level such that the data could be analyzed (e.g., Alaska and Oklahoma).

DRH is concentrating on how they can improve relationships between state PRAMS programs and tribes, and work with tribes closely to hear the stories of American Indian and Alaska Native women and children and to work with tribes to implement interventions and programs. With the influenza pandemic last year, some funds became available. DHR applied for those and requested that they be able to use PRAMS data to obtain more information about the influenza experience of Native American women. They received funds for four PRAMS states with large American Indian populations. Each state will have funding to employ a tribal oversight employee to work with PRAMS to reach out to tribes and set up a tribal oversight committee. The first order of business for each of those states will be to supply the tribes within those states with information about influenza. This will get data flowing to the tribal level to be used for decision making. If they improve response rates among American Indian women to answer questions about influenza, they will improve response rates on PRAMS questions across the board. These types of endeavors are a way to get CDC to use existing systems to better serve tribes and to strengthen natural partnerships.

There has been one tribally led PRAMS program in the US, which is in South Dakota. This PRAMS is led by the Yankton Sioux Tribe, with 9 tribes in the state participating. The South Dakota PRAMS obtained a response rate of 72.9%, and that model will be used in the 4 funded states for outreach to tribes in those states. She pointed out that the data manager and acting tribal epidemiology center director, Jennifer Irving, was present in the consultation. While this effort is not program delivery, it represents an area in which they need to strengthen their partnerships. In times when fiscal resources are limited, there are many untapped resources the agency can take advantage of to support tribes.

Regarding misclassification, Ms. Tucker reported that a number of state-specific studies have been conducted. This is an area where she thought DRH could offer “shoulder to the wheel” support. They can work with tribes to broaden and deepen these studies and to identify the optimal ways to examine and analyze this issue, and share what they find.

Jennifer S. Irving, MPH
MCH Epidemiology Coordinator
Northern Plains Tribal Epidemiology Center

Ms. Irving clarified that the surveillance report includes statewide surveillance. It does not include tribe-specific information. The tribe-specific reports go directly back to the tribes and are not made public at the request of the tribes. She emphasized that information is power. As a direct result of some of the work they have done on PRAMS, some tribes have applied for pre-conception health funding, breastfeeding funding, funding for more public health nurses at their local IHS clinics, and small grants for car seat training. They are very proud of the South Dakota Tribal PRAMS project because it was the first tribally funded PRAMS project, it was tribally led, and a lot of credit needs to be given to the Council of Yankton Sioux Tribe and the President as well.

Open Testimony

Tribal Testimony

**Alicia Reft, President
Karluk Ira Tribal Council**

Ms. Reft reported that the Alaska Native Health Board (ANHB) has recently appointed a new President and CEO. Listening to the issues discussed over the last couple of days, she wanted to speak on behalf of her area. It is a vicious circle that they deal with. There are the issues of drugs and alcohol, and it hurts and it is difficult to talk without crying. She is one of the very few from her area who has never had a drink in her life or smoked. She has big family, and they have done it all, and they struggle. The leaders in the area struggle with these issues themselves, so it is hard for them to speak up against it and feel like hypocrites. It is not that they do not want to help. Maybe they had issues when they were growing up and did not get help with them. It is just hard to function sometimes. Then their children see this and think it is okay, and they do the same. Ms. Reft feels like a failure being with a tribe and a leader, that without the support of the people around them, it is not clear how to stop. It is really hard. While people say that the Alaska Native Health Consortium (ANHC) and the ANHB are doing great things, she does not see it in her area. The previous day, she got a call that there was a bomb threat at Kodiak High School, which resulted in all of the schools on the island being on lock down. Drugs were found in lockers. They know these things are going on, but they do not know how to stop it. Tribes do not have anything to do with that school, but because they were trying to find out about the bomb threat, they have arrested high school youth. That hurts, too. Everyone talked about teen pregnancy and suicide. They experience these even though they come from small communities of towns of 40 people. Nothing is being done about it. They do not talk about it because do not want to hurt the elders, or the elders are not going to talk about it because they may have a problem. It is not clear whether they can get support.

Everyone wants to talk about why people drink and use drugs, but those are excuses. People praise her for never drinking, but it is the people who drank and have stopped who amaze her when she hears how hard it is to stop. She is angry about it, but no one wants to listen to her because she does not smoke or drink. She praises those who have been there and have turned it around, but the situation has gone from bad to worse. Last year at the consultation meeting, they sat there and just talked about the problems and went round and round, but nothing is being done about it. She thought it would be better for her travel money and per diem to be used for HIV testing because she did not feel effective. She gets really frustrated when she hears people praise Alaska for doing the Health Aid Program, but in the last couple of years

they no longer have had counselors go to the villages to talk to the youth. These programs are being taken away and the villages do not know why, and they do not have the funds to put into the community. She feels that some of the problem is the leaders of the larger organizations like the regional health corporations. It seems that depending on whether people are there for the money or the prestige, when leadership changes, the priorities change and good programs that were working are taken away.

There has been a big deal with the internet. She has to go home to her community to work with the school district and her tribe to turn the internet off and have it restricted. The internet was a way for children to communicate with other children because it is a small community, but it turned out not to be good. Growing up, children played outside and had other things to do and it was a lot simpler. She does not envy those who are trying to raise children today because everything is about the internet and video games. She does not know how it will be taking this away from them, but they have to do something. She was hoping that would not happen, but people are asking for help. She does not know what CDC can do. The TCAC and its representatives all share a lot of the same missions. They do not know how to resolve the issues, or how to help the youth become part of the solution before they become part of the problem.

Years ago they talked about Kodiak High School having a clear vacuum that would show what smoke would do the lungs. This made a huge impact at the time. Now their young people are smoking as young as age 15. Having a small population, it is difficult to get the grants to build someplace for the children to go in the wintertime. They have a lot of cold and darkness. They have someone who would like to build a greenhouse, but they do not have the capacity to write the grants. They are shareholders of corporations, but they do not listen to the ideas for their communities. She thought if they could just get the funding for a good grant writer, they might be able to get somewhere. She hears from a lot of areas with great ideas. They hear a lot of good information from Portland. If there was a specific site for a think tank to go for everything, like a one-stop-shop for ideas, people's success stories, and how they did it, that would be great.

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

Ms. Hughes highlighted two areas. Many cancers among American Indians have dramatically higher rates than whites in the Midwestern region of the country. In 2008, their researchers investigated the medical records of nearly 29,000 American Indians and Alaska Natives who were diagnosed with cancer between 1999 through 2004. These studies show that American Indians in the Midwest region had significantly higher rates of several types of cancer. The rate of liver cancer was 197% higher for Native Americans than for non-Hispanic whites, and the rate for gallbladder cancer was 148% higher. Again, this is a funding need. There is a critical need for outreach in the tribal communities. One example of outreach in Wisconsin that they are trying to keep in place consists of support groups and general education. A grassroots group, "Share the Care," is trying to do a lot of work. They collaborate with the "Pink Shawl" group and do this with little funding. Survivors are brought into the annual "Share to Care" conference to share their success stories and promote screening because there are so many cancers now that can be prevented if caught in the early stages. Funding is an on-going problem in terms of having the ability to do outreach and education that are needed. Ms. Hughes said she was making a list of suggestions made during this meeting for reaching out, which included funding, support from CDC, educational materials that will mean something in tribal communities, access

to information (e.g., compiling success stories and disseminating them; developing some type of clearinghouse).

Emergency management and Homeland Security is another area that is suffering severe cutbacks, which has been on-going since the inception of the program. Oneida's emergency preparedness program is almost fully supported by funding from CDC. It is known that many of those programs will be cut in the coming year. The program overall is receiving decreased funding, and some programs will be completely terminated. She expressed her hope that there would be consideration for reevaluating those cuts. Homeland security issues in this country are not going away. Everyone has just gotten to the point of implementing programs that are not even expanded to the point of giving them full value yet, but already the funding is disappearing. Ms. Hughes requested that the existing funding be kept in place for a usable amount of time, perhaps 5 years versus 1 to 2 years, in order to achieve good results and have it at a sustainable stage without requiring constant support.

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

Ms. Abramson reported that the NIHB represents 564 tribes and that it was on their behalf that she presented this testimony. She thanked CDC representatives for the opportunity to present testimony concerning the CDC National Public Health Improvement Program and the infrastructure investments in state, tribal, local, and territorial health departments. The NIHB recognizes the efforts of CDC to strengthen and improve public health infrastructure and performance through various initiatives supported by what is now called the Office of State, Tribal, Local, and Territorial Support. Such initiatives include public health accreditation; national public health performance standards programs; local and state health department profiles produced by NACCHO and ASTHO; Healthy People 2020; and the recent national public health improvement program that made funding available to state, tribal, local, and territorial health departments and organizations.

A number of economic challenges and infrastructural issues have led to a decline in the implementation of the essential public health service across the US. Essential services such as disease detection and monitoring, vital records, and health information technology are operating at minimal levels. Program capacity in chronic disease, injury, labs, environmental health, and other areas are at risk. Without a sustained commitment to infrastructure investments and essential public health services, the protections provided by the nation's public health system will fail. It is known that performance-based improvements have a strong likelihood of improving the volume and health impact of public health services. Such improvements include improved efficiencies, cost savings, leadership development, and utilization of tools and strategies that improve quality. While CDC has made a significant investment in creating standards for performance, increasing the capacity of organizations such as NACCHO, ASTHO, National Association of Local Boards of Health (NALBH), and others, NIHB continues to be excluded as a national partner with CDC in performance improvement initiatives. Such exclusion has a direct impact on tribes. Nationally, CDC has invested a great deal to assess and build the capacity and performance of local and state public health systems. However, very little has been invested to build tribal public health systems. NIHB recognizes this gap and continues to try to be at the forefront to ensure that tribes are included. For example, NIHB conducted a feasibility study of tribal participation in public health accreditation. The study determined that tribal public health accreditation is feasible, and a summary of results was put into a strategic plan with short- and long-term strategies to include tribes in accreditation. A number of these

strategies are being successfully implemented, including the development of tribal standards and measures.

The Public Health Accreditation Board (PHAB) has partnered with NIHB to ensure that tribal standards and measures are developed through a process of tribal consultation, and that the resulting accreditation program is relevant, applicable, and culturally appropriate for tribal settings. The PHAB tribal standards and measures are scheduled to be released just prior to the launch of the accreditation program. NIHB recently released the 2010 National Tribal Public Health Profile summarizing tribal public health performance activities and services. As was mentioned previously, profiles exist for local and state health departments that cover the last decade and were conducted through funding from CDC. Given that NIHB does not currently receive CDC funding to conduct public health systems research, NIHB was able to use funds from an alternate source to create the profile that is modeled after the local and state profiles and includes other indicators specific to tribes. Due to NIHB's foresight and initiative, there will now be baseline data for a number of the Healthy People 2020 performance objectives that would have otherwise been unavailable.

NIHB is current conducting other public health systems research to harmonize the data collected in the tribal profile with the local and state profiles, and exploring tribal readiness for accreditation. The results of this project will be the first reports and articles to describe public health performance that includes all systems—local, state, and tribal. The significance of such work will contribute greatly to the understanding of our nation's public health system as a whole. The other area that this project explores is tribal readiness for accreditation that will inform the level of technical assistance needed to improve tribal public health capacity.

These are just a few examples of the contribution that NIHB has made to the larger national initiative to improve public health performance and capacity. However, all of this has been achieved though funding from other sources. CDC's OSTLTS includes tribes in its mission and name only. NIHB holds a cooperative agreement with CDC and has been conducting work under this agreement. Despite their efforts to obtain funding to conduct this important work to raise the level of support, technical assistance, and quality improvement for tribes, their requests remain unanswered. Meanwhile, the organizational partners working with local and state health departments continue to receive funding to elevate public health performance for the rest of the US population. More recently, CDC national public health improvement program funds have gone to an organization serving state health departments to provide technical assistance to 8 tribal grantees. How can an organization that has little to no knowledge of the complexities of tribal health provide competent technical assistance to tribes? This is unfair and unjust.

Since its establishment in 1972, the NIHB has served federally recognized American Indian and Alaska Native tribal governments by advocating for the improvement of health care delivery to American Indians and Alaska Natives. The NIHB ensures that the federal government upholds its treaty obligations to American Indian and Alaska Native populations in the provision and facilitation of quality healthcare to native people. NIHB respectfully requests that tribes be given the same level of funding, support, and resources to build their public health performance and capacity as local and state governments. NIHB has demonstrated its leadership and capacity to provide the research, resources, technical assistance, and training to tribes in the area of public health performance and capacity. Funding for tribal public health performance and capacity needs to go directly to tribes through the NIHB cooperative agreement—not a non-tribal organization. The federal government provision of health services is critically important for American Indian and Alaska Native tribes. This is not only because of the unique relationship

that exists under the Constitution between the federal government and the tribes, but also because tribal communities generally face far greater health risks than the general population. A strong relationship between CDC and tribes is critical to achieving positive health positive health outcomes across Indian Country.

J.T. Petherick
Health Legislative Officer
Cherokee Nation

Mr. Petherick indicated that he was not able to attend the previous day's meeting, but the agenda included a discussion about the public health accreditation process. The Cherokee Nation is a beta test site, and has participated in other workgroups that addressed the tribal standards and measures. One of the concerns they have heard a lot from tribes throughout Indian Country and state and local governments was about how accreditation will be treated in terms of the funding activities of CDC and other federal agencies. A general thought they have heard is that the accreditation process should be a valuable tool to increase public health capacity and activities, but it should not be punitive. There are tribes in Indian Country that are prepared to apply immediately to be accredited, but other tribes do not have that capacity currently. Thinking about the government-to-government relationship, it does not make sense that tribes would be harmed as far as funding or other grant opportunities because they are not accredited. There are many unanswered questions right now because the accreditation process has not yet been finalized, but this seems to be the major concern. He commended OSTLS for working to address flexibility in the grant process.

Regarding the discussion about the accreditation process, Ms. Hughes thought it gave those present a better understanding about what the process was meant to be about and emphasizing that it is a voluntary process. It was suggested that additional comments be sought about standards. A specific question was raised about how they could determine incentives to get tribes to participate in public accreditation. Tribes are already going through another accreditation process that is not eliminated by engaging in the public health accreditation process. In essence, tribes would have to engage in both processes—one for IHS and one for CDC. While agency representatives did not state that tribes would lose out on funding by not being accredited, it was suggested that there possibly would be other funding made available for those who received accreditation.

CDC Responses

Dr. Ursula Bauer, Director
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Bauer acknowledged that the federal government created a lot of problems and has not been as effective in solving those problems. Once a problem is started, it has a way of taking off and strengthening on its own to become a worse and worse problem. One a solution is started, that can have the same snowball effect and can spread. NCCDPHP has struggled to get the solutions started and to disseminate them widely so that they can take hold and grow on their own. These problems are great across Indian Country and across the US. CDC has a role in helping to solve the problems, but cannot do it alone. Echoing CAPT Tucker and Dr. Frieden, one thing the agency can do is to identify the successes / solutions that have worked in some places and do a much better job of getting those into the hands of people who can help them

flourish in individual communities—picking on Secretary Sebelius’s request to ensure that the lessons learned from CPPW really get out into communities. NCCDPHP can assess some of the solutions to the types of problems that have been described and do a better job of getting information about these whether they are simple, cheap, difficult, or expensive.

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

Mr. Seneca indicated that he and Craig Thomas participated in many of the same workgroups related to tribal accreditation. There has not been any definitive discussion about funding related to accreditation. Dr. Monroe chairs the PHAB, and they have not discussed any funding being tied to accreditation. They have discussed the need for incentives in order to entice tribal health departments to participate in this process. They know that the incentives would have to be different in Indian Country than with other state and local health departments. CDC is looking to TCAC to help determine what those incentives should be. It was mentioned that perhaps one incentive would be to streamline the grant and administrative processes for accredited facilities. He believes that this really puts public health on the map in Indian Country versus basic clinical care that IHS provides, noting that the previous day, Mr. Finkbonner said that it “defines” public health in Indian Country.

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

Dr. Monroe indicated that accreditation grew from the field. CDC and the Robert Wood Johnson (RWJ) Foundation have been funding partners in the exploration and creation of public health accreditation. PHAB is the accrediting body, and it is comprised of representatives from the field. CDC is not the accrediting body. The accrediting body is an independent 501(c)(3) entity, which is typical of most accrediting processes. This is very much in the developmental stage, and CDC has not seen all of the results of the beta tests yet. It will take several years for this to unroll, so there is still ample time for a lot of discussion and consideration.

Recap / Closing Prayer

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

Ms. Cantrell thanked everyone for this and the previous two days, which she thought were highly productive. She thought that as they moved forward, their relationships would grow and they would be able to build upon them. She clearly heard the need to disseminate stories to tribes about what works, and to provide some type of central location where best practices could be housed.

Melanie Duckworth, PhD

**Acting Senior Public Health Advisor, Technical Assistance Branch
Office of State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention**

Dr. Duckworth said she thought that Dr. Frieden did a great job in terms of giving them an overview about winnable battles and how they relate to AI / AN populations. She said she was really thankful to all of the tribal leaders for giving them some really good examples in terms of what is happening in their areas. OSTLS plans to follow up with all of the programs who had representatives attend the meeting to provide the recommendations that were made, and to ensure that the TCAC members have all of that information as well. In the next meeting, they will focus on the next three winnable battles. It is important to continue to engage with TCAC and for TCAC members to continue to highlight certain areas that CDC needs to focus its attention on.

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

Dr. Monroe thanked everyone for all of the great information provided over the last three days. She said she received some pretty extensive notes sent to her from staff, which were prepared by the Cambridge Communications Writer / Editors, with a great deal of detail and she knew that Dr. Frieden enjoyed his time during the consultation process. She thanked Ms. Hughes for chairing this meeting without her fellow co-chair. OSTLS has a lot to think about, given the amount of input. She heard clearly that it is important to develop a matrix of what has been recommended and the status of each recommendation. There are many recommendations that they can do something about, and there are some that other partners can address. Having the matrix will help to sort this out. She pledged that OSTLS would work on that matrix moving forward. She said she was personally excited that they have formalized a work group across CDC for AI, AN, and Hawaiian Natives to bring everyone together. That work group is going to be a real benefit for CDC. She talked to Dr. Frieden, and one of the things they want to ask that work group to do is convene grant reviews that draw colleagues from across CDC who are American Indian, Alaska Native, or Hawaiian Native to ensure that the grant review process is populated such that this background is included on review panels. The first charge to the work group may be to help them figure out how to do this. She noted that she just came from a winnable battles meeting in which they were addressing motor vehicle injuries. The work that NCIPC is doing with tribes in this area is quite exciting. In conclusion, Dr. Monroe thanked everyone very much for their participation and assured them that CDC and OSTLS would keep trying to improve.

**Kaipo Akaka, Epidemiologist
Office of Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention**

Mr. Akaka said that he was honored to be present as a formally invited member of the Native American Coalition, the goal of which is to better serve native communities. Hopefully, CDC can help to answer some of the problems.

He said that years ago when he was taught to pray in his native language, he was taught to begin by saying [he indicated that he would send the native language to Kimberly so that she could provide it to us], which means "make yourself right so you can pray." The long version means "actively making yourself right before the Lord, before your creator, to communicate with

Him.” He was also taught that it was disrespectful to leave anyone out of a prayer. He then offered the closing prayer.

Attendance Roster

Tribal Consultation Advisory Committee (TCAC) Members

Cathy Abramson, Saulte Ste. Marie Chippewa Indians
Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board
Kathy Hughes, TCAC Co-Chair; Bemidji Tribe; Vice Chairwoman, Oneida Business Committee
Candida Hunter, Hualapai Tribe
Sherrilla McKinley, Inter Tribal Council of Arizona, Inc.
Brenda Neilson, Executive Secretary, NPAIHB, Quileute Tribe
David Nez, Coordinator, Public Health and Emergency Preparedness Response, Navajo Nation
J.T. Petherick, Health Legislative Officer, Cherokee Nation
Alicia Reft, President, Karluk Ira Tribal Council

Other Tribal Representatives

Stacy A. Bohlen, Sault Ste. Marie Chippewa; Executive Director, NIHB
Bridget Canniff, Northwest Portland Area Indian Health Board; Project Director, Tribal
Epidemiology Center Consortium
Virginia Myers, Program Coordinator, California Tribal Epidemiology Center, California Rural
Philene S. Herrera, Division of Health, Navajo Nation Indian Health Board; Member of the
Yurok / Karuk Tribe

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Annabelle Allison, Tribal Affairs Liaison, NCEH / ATSDR
Ursula Bauer, Director, NCCDPHP
Holly Billie, Injury Prevention Specialist, NCIPC
Kimberly Cantrell, Tribal Liaison, OSTLTS
Kevin Collins, Office on Smoking and Health, NCCDPHP
Melanie Duckworth, Senior Public Health Advisor, OSTLTS
Thomas R. Frieden, Director, CDC; Administrator, ATSDR
Bridgette Garrett, Office on Smoking and Health, NCCDPHP
Wayne Giles, Director, Division of Adult and Community Health, NCCDPHP
Alicia Hunter, Division of Nutrition, Physical Activity, and Obesity, NCCDPHP
Brick Lancaster, Senior Advisor, Office on Smoking and Health, NCCDPHP
Tim McAfee, Director, Office on Smoking and Health, NCCDPHP
Judith A. Monroe, Deputy Director, OSTLTS
Michael Sells, Division of Nutrition, Physical Activity, and Obesity, NCCDPHP
Dean Seneca, Environmental Health Scientist, OSTLTS
Alison Spitz, Division of Reproductive Health, NCCDPHP
Myra Tucker, Division of Reproductive Health, NCCDPHP
Nancy Williams, Division of Nutrition, Physical Activity, and Obesity, NCCDPHP

Others

Stephanie Henry-Wallace, Writer / Historian Cambridge Communications & Training Institute
Amy Johnson, Writer / Historian Cambridge Communications & Training Institute

Appendix: Tribal Testimony Submitted in Writing

None submitted