



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

**Tribal Consultation Advisory Committee (TCAC) Meeting and
4th Biannual Tribal Consultation Session**

**January 26-28, 2010
Executive Summary**



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Tribal Consultation Advisory Committee (TCAC) Meeting

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The purpose of the Tribal Consultation Advisory Committee (TCAC) to the Director is to advise the Director of CDC and Administrator of ATSDR, on policy issues and broad strategies that may affect American Indian / Alaska Native (AI/AN) tribes and people. The TCAC assists CDC in fulfilling its mission to promote health and quality of life by preventing and controlling disease, injury, and disability through established and on-going relationships and consultation sessions. CDC honors the sovereignty of AI/AN governments, respects the inherent rights of self-governance, commits to work on a government-to-government basis, and uphold the federal trust responsibility. The TCAC provides a forum for meetings between CDC leadership and elected or appointed tribal leaders (or their designated employees with authority to act on their behalf); as well as representatives of national tribal organizations designated by tribal leaders to act on their behalf, in compliance with the exemptions with the Federal Advisory Committee Act (FACA). The meetings facilitate the exchange of views, information, or advice concerning the intergovernmental responsibilities in the implementation and / or administration of CDC programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. Such meetings include, but are not limited to, seeking consensus, exchanging views, information, advice, and/or recommendations, or facilitating any other interaction relating to intergovernmental responsibilities or administration. Meetings may be face-to-face or via



conference call. TCAC meetings complement and do not supplant the Tribal Consultation process between CDC and Tribes.

The TCAC Meeting itself was convened on January 26-27, 2010; a Tribal Leader Orientation was convened on January 27, 2010; and the Tribal Consultation Session was convened on January 28, 2010. A number of presentations were made during the TCAC Meeting, TCAC Orientation Session, and Tribal Consultation Session, which are very briefly summarized here. These presentations may be read in their entirety in the following detailed summary documents:

- January 26-27, 2010 TCAC Meeting Summary
- January 27, 2010 Tribal Leader Orientation Summary
- January 28, 2010 Tribal Consultation Session Summary

During the January 26-27, 2010 TCAC Meeting, members first approved the agenda and then addressed the administrative matter of approving the TCAC August 11, 2009 and August 13 2009 minutes. The minutes were approved unanimously, with minor edits to be submitted to CAPT Snesrud and Dr. Bryan.

TCAC members presented their regional / national updates, which included highlights of new or critical public health issues occurring since the February 2009 TCAC meeting. The following members offered updates: Derek C. Valdo (Pueblo of Acoma, Southwest Area Regional Vice President, National Congress of American Indians); Roger Trudell (Chairman, Santee Sioux Tribe of Nebraska, Aberdeen Area); Joe Finkbonner (Executive Director, Northwest Portland Area Indian Health Board); Dee Sabattus, Interim Director, Tribal Health Program Support, Nashville, United South and Eastern Tribes); JT Petherick (Health Legislative Officer, Cherokee Nation, Oklahoma City Area); Roselyn Begay (Navajo Nation, Division of Health, Program Evaluation Manager); Lester Secatero (Chairman, Albuquerque Area Indian Health Board), Cynthia Manuel (Councilwoman, Tohono O'odham Nation, Indian Health Board Tucson), Reno Franklin (Chairman, California Rural Indian Health Board), Chester Antone (TCAC Chair, Councilman, Tohono O'odham Nation, Tucson), Alicia Reft (Alaska, Karluk Ira Tribal Council), and Kathy Hughes (TCAC Co-Chair, Vice Chairwoman, Oneida Business Committee). The following members articulated that they would be submitting written reports as well: Mr. Antone, Ms. Begay, Mr. Finkbonner, Mr. Franklin, Ms. Reft, Ms. Manuel Ms. Sabattus, Mr. Secataro, and Mr. Trudell.

Major health issues that resonated from the TCAC members' updates and throughout the meeting that continue to plague Indian Country, often at higher rates than in the general population, include in alphabetical order: cardiovascular disease, cancer, child / adult obesity, diabetes, hepatitis C, sexually transmitted diseases, and suicide. It was noted that often when information is reported about tribes, it is "awfulized" with no solutions offered. However, in addition to articulating their health issues, TCAC members also described some of the methods by which they are attempting to address these issues in Indian Country, which include: Census participation, community gardens and tribally-owned farms, Community Health Representatives (CHRs), Head Start and school nutrition and physical activity programs, health care reform activities, healthy snack programs, medicine wheels, prevention / intervention / screening programs, Public Health Accreditation Board (PHAB) beta test site participation by several tribes, Tribal Epidemiology Center activities, wellness calendars with healthy recipes, and wellness facilities. With respect to the novel H1N1 pandemic, TCAC members reported that the success of vaccination efforts varied widely. Despite best efforts, there were areas where



insufficient vaccine was available and areas where leftover vaccine may expire unused. It is anticipated that once the data are reviewed, higher vaccine uptake will be observed in areas where tribes were treated as true partners.

Tribes reported a number of overarching issues that contribute to persistent health problems. Foremost is a lack of resources, which is compounded by state budget deficits. Some states have even demanded that tribes return funds. Contributing to the on-going financial issues is that the quality of tribes' relationships with states varies widely. In addition to some states not parsing out funds to tribes as they should, they also fail to provide tribes with data sharing agreements and vital local data pertaining to tribes. These data are imperative for many funding opportunity announcements (FOAs) for which tribes could apply themselves. TCAC members pointed out that this also represents a failure to honor treaties and recognize government-to-government relationships, and they emphasized the importance of, and right to, direct funding to tribes.

Smoking continues to be a major contributor to health problems in Indian Country; however, this is a difficult issue to address given the economic implications. Tobacco sales represent an important source of funding. The issue of ceremonial tobacco versus commercial tobacco must also be taken into consideration. Tribes are attempting to address the smoking issue in various ways. For example, the Oneida Nation is working on a tribal law that will implement a smoking ban in part in some public facilities, but which will protect casinos by continuing to permit smoking in these facilities. Other issues that continue to affect health include difficulties in maintaining staff in some areas, lack of health care due to some areas being highly remote and / or experiencing inclement weather that does not permit those who live there to get out or health care personnel to get in, border issues for Tribes residing along the Mexico / US border, and illnesses from previous mining operations and the potential reopening of uranium mines on some reservations.

With respect to the CDC organizational improvement effort, TCAC members expressed concern that TCAC did not have sufficient input into organizational change. Members expressed surprise to learn that the proposed new structure was published in the December 28, 2009 *Federal Register* as a completed effort rather than first being published for comments. In reviewing the proposed new organizational structure, it was noted that TCAC appeared to have lost ground and that the relationship they were trying to formulate with CDC was taking a step backward under the new administration and new organizational structure. The rationale behind the transition of Tribal Affairs from the Office of Minority Health and Health Disparities (OMHD) to the Office of State and Local Support (OSLS) was explained, but TCAC members remained troubled that the OSLS did not actually include the word "Tribal." They felt that this was an important oversight that again undermined the notion of treaties and government-to-government relationships. OSLS representatives assured TCAC members that addressing Indian Country issues would be a priority in this new office.

Luke Johnson (Public Health Emergency Preparedness Coordinator, Fort Mojave Indian Tribe) and Brenda Granillo (Director, Arizona Center for Public Health Preparedness) reported on the *Arizona Tribal Public Health Preparedness Strategic Plan*. They described the strategic planning process, purpose, plan components, timeline, mission / vision / goals, benefits, challenges, and next steps. The *Arizona Tribal Public Health Preparedness Strategic Plan* is a "living document" that will continually be updated to meet the challenges of bioterrorism or disease outbreak.



Dr. Mick Ballesteros, Associate Director for Science, offered an overview of the mission, vision, organizational structure, divisions, priority areas, research agenda, and resources of CDC's National Center for Injury Prevention and Control (NCIPC). Dr. Alex Crosby of NCIPC's Division of Violence Prevention (DVP) described the public health approach taken by NCIPC and its divisions, and reviewed data and FVP programs specific to American Indian / Alaska Native (e.g., Selected activities in violence prevention among Native Americans; enhanced evaluation of the Garrett Lee Smith funded suicide prevention act; collaboration with Tribal Epidemiology Centers, health disparities meetings, et cetera). CDR Holly Billie then described evidence-based programs implemented in tribal communities, including: effective strategies to reduce motor vehicle injuries among American Indian Tribes; elder fall prevention collaboration with HIS; highway safety collaboration with IHS, BIA, NHTSA; and Native American injury prevention web pages.

Wayne Giles, MD, Acting Deputy Director presented an overview of the National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP). He discussed the burden of chronic disease and described NCCDPHP's organizational structure, divisions, public health strategy, priorities, and contribution to public health in the American Indian / Alaskan Native communities. Dr. Marcus Plescia, Director of the Division of Cancer Prevention and Control (DCPC) offered an overview of the division and described a number of programs implemented by the division in terms of how they specifically addresses tribes (e.g., National Breast and Cervical Cancer Early Detection Program, Colorectal Cancer Control Program, Tribal Comprehensive Cancer Control Programs); and programs specifically focused on tribes (e.g., data linkages in NPCR to improve cancer burden data; research on AI/AN experiences with cancer prevention and treatment, and colorectal cancer prevention projects with Tribal Epidemiology Centers). Opportunities include continuing work with NPCR and IHS to link cancer incidence data for AIs / ANs; providing support for tribe and tribal organization cancer prevention and control programs; and continuing research into AI/AN cancer disparities.

Dr. Nell Brownstein, of NCCDPHP's Division for Heart Disease and Stroke Prevention (DHDSP) described the mission, vision, organizational structure, and priorities of DHDSP. She reported on heart disease and stroke in AI/AN populations versus the general population, and described DHDSP programs specific to tribes (e.g., WISEWOMAN Tribal Programs and toolkit, Montana's Cardiovascular Health Program and collateral materials). A potential opportunity with this division is the research study titled "Reducing Time to Treatment for Myocardial Infarction (MI) for Rural American Indians and Alaska Natives." Dr. Myra Tucker, Tribal Liaison for NCCDPHP's Division of Reproductive Health (DRH) offered an overview of the division, and described previous tribal-specific work (e.g., 30 Tribal Behavioral Risk Surveys; and Research titled "Risk Factors for Sudden Infant Death Syndrome Among Northern Plains Indians), as well as current work with tribes (e.g., capacity-building; surveillance; research; emergency response; and cross-cutting themes in working with tribal entities for all activities, and providing appropriate data / enhancing the knowledge base). Future activities are to maximize use of existing data systems on behalf of AI/AN Maternal and Child Health (MCH), and to develop tribal data systems and tribal epidemiology programs.

Dr. Linda Crossett of NCCDPHP's Division of Adolescent and School Health (DASH) explained the role of DASH in addressing six priority risk behaviors for youth (e.g., behaviors that result in intentional and unintentional injuries, alcohol and other drug use, sexual behavior, tobacco use, dietary behavior, and physical inactivity). She described DASH's surveillance systems and a



few of the many other tools that CDC has developed to help schools implement science-based, effective programs to combat these six priority areas. In addition, she described a number of activities addressing risk behaviors specifically among American Indian / Alaska Native youth (e.g., technical assistance and funding for the YRBS, funding of some Tribal Governments to implement school health programs, activities supported through State Education Agency cooperative agreements, training in evidence-based tools, and Expert Panel titled “Adolescent Suicide: Addressing Disparities through Research, Programs, Policy, and Partnerships” convened in September 2009, and an upcoming article titled, “Health Risk Behaviors Among American Indian and Alaska Native High School Students in the United States, 2001-2007.” Additional opportunities with DASH include training and professional development, expansion of funding opportunities to support implementation of the YRBS and school health programs, and collaboration with other divisions and offices across CDC.

Dr. William Kohn of NCCDPHP’s Division of Oral Health (DOR) described DOR’s mission, vision, and primary activities and programs, as well as specific AI/AN efforts (e.g., Healthy People 2010 / 2020 activities; assistance in 2009 in developing and Alaska YKHC Epi-Aid on caries in children; provision of \$50,000 for water fluoridation improvement to improve fluoridation in Alaska; help with accreditation of the IHS Residency Program; provide speakers at conferences; and in 2004-2008 was represented on the IHS National Health Promotion / Disease Prevention Committee). He also reviewed data on AI/AN dental caries, and described future opportunities (e.g., surveillance consultation and inclusion of tribal disease data on the National Oral Health Surveillance System (NOHSS), assistance with remote monitoring of fluoridated water systems, and quality assurance monitoring of tribal water systems through the CDC Water Fluoridation Reporting System (WFRS)).

Dr. Rosanne Farris of NCCDPHP’s Division of Nutrition, Physical Activity, & Obesity (DNPAO) explained DNPAO’s mission, vision, goals, and priorities areas. She also described various DNPAO tribal efforts in breastfeeding and / or physical activity in Montana, Michigan, New Mexico, and Minnesota. Potential opportunities with DNPAO include increasing the number of program examples, tailoring interventions to specific culture and health priorities, and enhancing capacity to work on other issues. Dr. Dianne May of NCCDPHP’s Office On Smoking and Health (OSH) described OSH’s vision, mission, and funding allocations (which includes the funding of 6 Tribal Support Centers). Current OSH AI/AN activities include an MOU with IHS to provide data analysis on the American Indian Adult Tobacco Survey (AI ATS), develop tribal funding recommendations, and conduct strategic planning. The American Indian / Alaska Native National Network cooperative agreement with the Inter-Tribal Council of Michigan provides training and technical assistance for tribes and tribal organizations on implementing / analyzing the AI ATS and to convene a national advisory board. The Tribal Support Centers capacity-building programs lead tribal efforts to reduce abuse of commercial tobacco and secondhand smoke exposure; and support implementation programs to implement and evaluate tobacco control strategies. Dr. May described several specific Tribal Support Center activities.

Dr. Lynda Anderson, Acting Director of NCCDPHP’s Division of Adult and Community Health (DACH) described DACH’s efforts in terms of center wide services, crosscutting approaches, and emerging issues. DACH’s REACH U.S. program funds 40 communities throughout the country to advance the prevention and elimination of health disparities among racial and ethnic minority groups and to understand and spread successful strategies for achieving significant changes at the community level. Forty REACH US Communities include 18 Centers of Excellence in the Elimination of Health Disparities (CEEDs) and 22 Action Communities.



CEEDs have expertise in working with specific ethnic groups and widely disseminating effective strategies. Under the REACH US program, CDC awarded 6 entities targeting the elimination of health disparities in American Indian communities, all six of which are fully engaged in intervention activities. Dr. Anderson also described DACH's Prevention Research Center (PRC) activities with AI/AN communities, as well as the American Recovery and Reinvestment Act (ARRA) Communities Putting Prevention to Work (CPPW) community grant program and evaluation.

Dr. Dawn Satterfield of NCCDPHP's Division of Diabetes Translation (DDT) reported on DDT's vision and mission, as well as its programs, priorities, and strategies in Indian Country. To address a prevalence of diabetes in the AI/AN population that is greater than two times that of Whites, Dr. Satterfield indicated that with its 2010 appropriation of \$66 million, this division strives to identify trends in diabetes incidence, prevalence, and mortality; and translate science to action by communicating evidence-based prevention messages and implementing effective public health programs. She described DDT's program dedicated to supporting diabetes prevention efforts in Indian Country, the Native Diabetes Wellness Program. The goals of this program are to support sustainable ecological approaches to restore traditional foods and activities in communities; and to share messages about traditional ways of health that are remembered, retold, and talked about in homes, schools, and communities. Since 2001, the National Institutes of Health, NIDDK, in partnership with the Tribal Leaders Diabetes Committee, CDC Native Diabetes Wellness Program, the Indian Health Service Division of Diabetes Treatment and Prevention, and eight tribal colleges and universities (TCUs), have developed the K-12 science and culturally based Health is Life in Balance Diabetes Education in Tribal Schools (DETS) curriculum.

Mr. Robert Curlee, Deputy Director of CDC's Financial Management Office (FMO) shared several tables representing CDC / ATSDR resources committed to programs that benefit American Indian / Alaska Native (AI/AN) populations and communities from 2009 compared to 2008. Fiscal information was summarized in the data presented according to organizational and disease-specific programs, and by defined funding allocation categories. Recovery act funding was not included in this information, nor had 2010 information been prepared at this time, although Mr. Curlee noted that there are some efforts underway. Mr. Curlee also described grants to tribes broken down by state, by HHS area, and by IHS area. Highlights are that total CDC / ATSDR funding with VFC (73%) is \$168,275,464. Total funding without the VFC is \$46,009,312 (27%). Excluding ATSDR, total funding with VFC is \$167,637,959 and without is \$45,371,807. In comparison to 2008, 2009 indirect AI/AN awards (with VFC) increased from \$65 million to \$123 million. AI/AN Fiscal Year 2009 funding (with VFC) in the amount of \$168 million represents 2% of the total CDC / ATSDR budget, while the \$45 million in AI/AN funding represents 1% of the total CDC / ATSDR budget. Of particular interest was Mr. Curlee's message that TCAC still had an opportunity to develop and submit a special project for inclusion in the 2012 CDC budget. To that end, he agreed to provide samples templates to give TCAC guidance on the types of projects that have been funded in the past.

Dr. Annabelle Allison of NCEH / ATSDR explained the goals of NCEH / ATSDR and described the activities of the Office of Tribal Affairs (OTA) during 2009 (e.g., collaborated with NCEH and ATSDR divisions on several tribal projects; conducted outreach at several meetings / conferences / forums; coordinated with others regarding NCEH / ATSDR's National Conversation; coordinated efforts with the Navajo Nation and others regarding uranium assessment and remediation; and is in the last year of 5-year cooperative agreement with two



Tribal Colleges and Universities: Turtle Mountain Community College in North Dakota and Dine College in New Mexico). Dr. Allison described the goal and activities of the National Conversation, including the six workgroups and tribal representatives (e.g., Scientific Understanding: Susan Hanson, Shoshone Bannock Tribe; Policies & Practices: Kristin Hill, Great Lakes Inter-Tribal Epi Center; Chemical Emergencies: Syndi Smallwood, Pechanga Band of Luiseno Indians; Serving Communities: Steve Crawford, Passamaquaddy-Pleasant Point Tribe; Education & Communication: Rosemary Ahtuanguaruak, Inupiat Community of the Arctic Slope; and Monitoring: Nancy John, Cherokee Nation). In addition, she reported on the health and environmental impacts of uranium on the Navajo Nation including the history, Representative Waxman's charge to give federal agencies (EPA, IHS, BIA, DOE, NRC) to develop a five-year plan to assess and remediate, and ATSDR past and future studies pertaining to uranium mining.

With respect to TCAC Recommendations / Organizational Improvements Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health explained two documents provided to TCAC members: 1) "A Summary Report for the 4th Biannual CDC Consultation Session January 28, 2010: Resource Allocations, Strategic Partnerships, and Capacity-Building," which he indicated was basically the CDC component of the HHS annual report just packaged separately for TCAC's use; and 2) "CDC Tribal Consultation Advisory Committee (TCAC) Update on Recommendations / Response January 2010," which lists 24 of the cumulative formal recommendations since the inception of TCAC in 2006 listed more or less chronologically. Recommendations will continue to be added to this list as formal recommendations are delineated during TCAC meetings and Tribal Consultation Sessions. No recommendations have been removed from the list to date as completed and done, because many of the activities, once implemented, are on-going. Some of the activities are partially implemented, in progress, or in transition. Of the 24 formal recommendations, a number have been implemented and are on-going. During this session, Dr. Bryan and CAPT Snesrud offered TCAC members an opportunity to respond to this document, and to offer feedback with regard to whether this format was the most useful for them. Several TCAC members articulated that they like this format. CAPT Snesrud explained that what they mean by "having an open door policy" was that although they do convene two specific bi-annual Tribal Consultation Sessions during which testimony can be provided by any and all tribal leaders, tribal leaders are still permitted to participate with HHS and, if there is a particular tribe that chooses to engage in a consultation, this can be recommended to CDC as well. No formal recommendations were made during the January 2010 TCAC meeting.

Stacey Ecoffey, Principal Advisor for Tribal Affairs, Intergovernmental Affairs, Department of Health and Human Services (HHS) reported that many changes are underway at HHS department-wide that appear to be positive for Indian Country and which should elevate tribal issues to the HHS agencies. Leadership members who have extensive histories with Indian Country now have much better access directly to the Office of the Secretary, and the Secretary has articulated plans for a lot of interactions with Indian Country. With respect to the Budget Consultation, she encouraged tribal leaders to join the calls to help plan the agenda. She stressed that HHS has always complied with and taken very seriously "Executive Order 13175: Consultation and Coordination With Indian Tribal Governments." The President's memo has made it a lot easier for the inner agencies to talk to each other about how to engage in consultation. All HHS agencies will be required to develop formal consultation plans. HHS is setting the dates for the consultations and is focusing primarily on the consultation policy process, the agency policies, and open tribal leader comments on consultations in general.



HHS will convene one-day sessions throughout the country in each region, with the exception of Regions 9 and 10 which will have two sessions given the large number of tribes in those two regions. She hoped the Secretary would have a letter soon and that she would be able to share the dates by the next week. These meetings will be convened from the end of March through the beginning of May 2010. They also plan to visit Indian Country during that time frame as well. They also plan to form a Federal Tribal Work Group that will meet over the summer. They will ask for nominations from the tribes for that work group in May or June, and will convene the first meeting of that group in July to review all of the comments heard internally and externally because this is a partnership and develop a better plan and determine which agencies need to be targeted to develop consultation policies. Plans are also anticipated to create a Secretary's Tribal Advisory Committee. There will soon be a budget roll out, for which there should be a webcast. Ms. Ecoffey will provide a link for the webcast as well as budget documents to TCAC. The consultation report should be published by the end of March. The HHS website is being improved. She stressed that when tribal leaders were developing their testimonies for the budget consultation, they would not have to offer a 101 and suggested instead using concrete tribal-specific examples, such as "If the budget is not improved in this area, X will increase" so that HHS can see where they need to target specific items in the budget for programs that will benefit Indian Country. While she could not always guarantee the secretary, Ms. Ecoffey encouraged tribal leaders to visit HHS.

Dr. Walter Williams, Director of OMHD, formally announced the transition of tribal affairs activities, including work on CDC's tribal consultation policy and working with TCAC and related affairs, from the Office of Minority and Health Disparities (OMHD) to the Office of State and Local Readiness (OSLS). He said in part for him this was a celebration of many accomplishments since they began their journey together in 2005. His recollection was that CDC was the first HHS agency to establish an agency tribal consultation policy. This work began in 2004 and the policy was actually adopted in 2005. Abundant work has been accomplished since that time, including the establishment of the TCAC. In 2008, OMHD was transitioned from its position in the Office of Strategy and Innovation (OSI) to the Office of the Chief of Public Health Practice (OCPHP). That transition occurred after a transition from an office that reported directly to the CDC Director, which had been in existence for 14 years. They had to deal with some of the concerns raised throughout this meeting with respect to position within the organization, when they found themselves having to report through another person to get information and action items to the CDC Director. During a very intensive process that took into consideration current functions, staffing, budget authority, et cetera, and asking critical questions with regard to the new CDC Director's priorities, it was determined that the tribal activities aligned best with OSLS. Most activities that are important to the programs that support Indian Country have not been affected, and others that are mission critical are continuing in other organizational components at CDC. Regarding the transition of responsibilities as a proponent for the CDC tribal consultation policy and work with TCAC from OMHD to OSLS, a primary focus is enhancing support for public health activities in tribal, state, and local communities. Dr. Williams perceived this as an opportunity for enhanced synergy with regard to state and tribal collaboration and enhancing state and tribal relationships, and stated that he was personally looking forward to continuing to work with the CDC Tribal Liaisons. The intent of OMHD is to continue its critical support of the critical areas in which they are partnering with TCAC to support.

Dr. Karen White, Acting Director of OSLS highlighted the work that had been done over the last several years in OMHD, and explained what that mean to CDC. Having a separation between



OMHD and tribes to move into OSLS has been a long time coming. She stressed that this was to be celebrated because finally tribes would be recognized as a separate entity, and that they should be working at the same level as state and local health departments and territories versus being within an umbrella of other work at CDC. She perceived this transition as a relay in the journey that Dr. Williams discussed. This is the next step and OSLS has been charged with the obligation and responsibility to ensure that this occurs. She made a promise to those present that this would move forward, and that she, Dr. Bryan, and CAPT Snesrud had already engaged in some discussions regarding what the next steps would immediately follow this TCAC meeting. She expressed her gratitude to Dr. Williams for the work he has done to bring this program this far, indicating that she would pick up the baton and move forward from there.

In closing the TCAC portion of the meeting, Ms. Hughes requested that in contemplation of a potential project to submit for inclusion in the 2012 CDC budget, which would be a priority for their first teleconference, the Budget Subcommittee be resurrected. Based on the discussion earlier in the morning, she pointed out that additional work also needs to be done to the TCAC charter, and there needs to be recognition of delegates and alternates to serve on this council. With this in mind, the following subcommittees were established:

Budget	Charter
Joe Finkbonner	Joe Finkbonner
Kathy Hughes	Reno Franklin
JT Petherick	
Roger Trudell	
Derek Valdo	

The entire TCAC will be notified about these two subcommittees so that anyone who is interested may participate.

Mr. Finkbonner reported that John Pipe, Councilman of the Fort Peck Tribe and member of the National Diabetes Indian Coalition (NDIC), passed on January 23, 2010 having succumbed to the complications of diabetes. This brought home the efforts that the TCAC was engaged in around the table, and called attention to the public health messages and prevention programs that they want to put in place. Mr. Pipe was one of many Native Americans who have passed as a result of complications of diabetes. His passing represents a great loss for Indian Country. He was a quiet man, but there was great wisdom in the words he did speak because he chose them selectively. To honor Mr. Pipe, as everyone bowed their heads to say the closing prayer, they lifted up Mr. Pipe, his family, and the community who lost a great leader.

An Orientation Session for Tribal Leaders was convened on January 27, 2010. During this session, tribal leaders were presented with the following:

- Overview of CDC Organizational Improvement Process
Louis Salinas, OD / Chief of Staff
- Office of Communications: Overview of CDC
Donna Garland, Acting Director, Office of Communications



- ❑ Overview & Importance of CDC Tribal Consultation Policy (Working Lunch)
CDC Tribal Consultation Advisory Committee
CAPT Mike Snesrud, OD / Senior Tribal Liaison for Policy and Evaluation
- ❑ Office of State and Local Support (OSLS)
Karen White, Acting Director of OSLS
- ❑ Office of Public Health Preparedness and Response (OPHPR)
Christine Kosmos, Division of State and Local Readiness Director (DSLRL)
- ❑ Office of Surveillance, Epidemiology, and Laboratory Services
Steve Thacker, Deputy Director
- ❑ Explanation of Epi Aids & Examples from Indian Country
Doug Hamilton, Epidemiologist, EIS Chief, OSELS

Following the Orientation Session for Tribal Leaders on January 27, 2010, the Tribal Leaders Caucus was convened.



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4th Biannual Tribal Consultation Session

**January 28, 2010
Executive Summary**

On January 28, 2010, the 4th Biannual CDC / ATSDR Tribal Consultation Session was convened at the Roybal Campus of CDC in the Global Communications Center. Dr. Thomas R. Frieden, Director of CDC and Administrator of ATSDR offered the welcoming remarks. During this time, he outlined and explained his five basic priorities, which are to: 1) Improve knowledge of what is occurring in communities through better surveillance, epidemiology, and laboratory services in order to better understand the problems and share that information (e.g., convey it in ways that are understandable and impactful); 2) support communities through the leadership responsible for health; 3) increase impacts in global health; 4) increase policy impact; and 5) through all of the activities of CDC focus on the bottom line of preventing illness, disability, and death. In thinking about 2010 and forward, there are at least six areas in which Dr. Frieden believes there are winnable battles that need to be fought from which a big difference can be made: Tobacco, Nutrition and Obesity, Hospital Infection Control, Motor Vehicle Injuries, Teen and Unintended Pregnancy, and HIV / AIDS. With respect to accountability, Dr. Frieden said that he saw these consultations as an on-going partnership to ensure that they are accountable to themselves and to each other, and that they think about the types of interventions in which



they can partner and be accountable for whether or not they occur. In closing, he said he was honored to be in attendance at the 4th Biannual CDC / ATSDR Tribal Consultation Session, and that he was looking forward to listening to and learning from their insights, perspectives, and suggestions.

Themes that emerged during tribal leaders' testimony to Dr. Frieden and CDC / ATSDR executive leadership included the following:

- Honor treaties and the United State's commitments to Indian Nations
- Honor tribal consultation policies
- Respect tribal traditions (e.g., prayers, ceremonies, healing, language, et cetera)
- Engage in direct government-to-government relationships with tribes
- Specifically include the word "Tribal" in the name of the Office of State and Local Support
- Strive for better interagency coordination
- Clarify where tribal recommendations now go in the agency
- Assist tribes in obtaining data sharing agreements and local data, which are vital to measure need and accomplishments and to apply for funding
- Redirect funds directly to tribes
- Develop funding opportunities specifically for tribes such that they do not have to compete with states and academia, and engage tribal reviewers in the grant review process who understand AI/AN people and their issues and traditions
- Decrease disparities in Indian Country by developing programs / materials / media campaigns specifically for AI/AN populations to address alcohol / drug problems, cardiovascular disease, cancer, child / adult obesity, diabetes, environmental health, hepatitis C, mental health, pandemic responses, sexually transmitted diseases (including the creation of National Native HIV Resource Center), and suicide
- Expand the thought process regarding priorities
- Recognize and respect that many problems faced by AI/AN communities are because of the history of how tribes have been treated
- Continue the consultation process such that tribal leaders are able to speak to the highest level of CDC

In response to the tribal leaders' testimony, Dr. Frieden thanked each of those present for taking time from their families, communities, and schedules to attend the Tribal Consultation and to share with CDC in order to reach a situation of better partnership. He said he thought he



learned something different from each person who spoke, and he appreciated that. He offered the following feedback, in no particular order, after which he departed:

- ❑ Regarding the name of the office, perhaps CDC made a mistake. If they make a mistake, they admit, fix it, and move on. Certainly, no offense was intended, and Dr. Frieden said that he had always felt that if offense was taken, it was usually not the problem of the person who took offense. This suggestion will be considered very seriously. One of the things that CDC has tried to do by creating this office focused on community health, whatever it ends up being named, is accountability. By that Dr. Frieden means not just that they need to do a better job of providing technical advice, data, more guidance and technical support, and more staff, but also accountability in the sense of tough love—that they are very frank with the groups with which CDC works in that they expect the funding to flow down to where the work actually needs to get done. As a City Health Officer for 7.5 years, he assured them that this was a standpoint that was very strongly in his perspective on programs.
- ❑ The Tribal Epidemiology Centers was not something with which Dr. Frieden was familiar until reading the background materials for this Tribal Consultation. He said he would be very interested in expanding CDC's cooperation with those centers. This is an area where CDC can definitely do more. He would like to learn more about the data access agreements in terms of what is not working and whether CDC can help in some way.
- ❑ Regarding direct funding, with the stimulus package, Communities Putting Prevention to Work (CPPW) there is a separate tribal track, so there will be direct funding. Unfortunately, this will not go to nearly as many tribes as CDC would like. However, CDC hopes that with that program, which focuses on nutrition and tobacco, is that they will fund some tribal communities, some large cities, some urban cities, and some rural cities enough so that they can really make an impact, demonstrate that impact, and serve as a model for other places. CDC was not able to fund tribes directly for H1N1. In fact, the agency was not able to fund in many ways because of the timeframe required. They had to try to make the government system move quickly, which is very difficult. However, tribes were quite prominent in CDC's planning in terms of the need to ensure that each state worked effectively with their tribal populations, which are believed to be, for whatever reason, at higher risk of serious illness from H1N1. This is something that Dr. Frieden was regularly both asking about and being briefed about, so he was able to confirm that it was taken very seriously. When there were any miscommunications, perceptions, or issues these were immediately raised and addressed. Thought must be given to organizations that aggregate groups, because 565 tribes is a large number.
- ❑ As several tribal leaders mentioned, money is scarce and will be for some time. They are dealing with the aftermath of a very unfortunate period of time when a lot of people made a lot of money, but people who needed money did not make much money. Now the consequences must be paid for very irresponsible financial approaches. It is not fair, and it means that they must do whatever they can in this time to better address inequalities and to be clear about making the best possible uses of the scarce resources there are. There is a real value to programs that are demonstration projects from which others can learn.
- ❑ In terms of the functions at CDC, Dr. Frieden would like to understand more, as they continue these Tribal Consultations in the future, what things are not being done from a



content perspective that tribes believe should be done so that they can be addressed specifically.

- ❑ With respect to inter-agency coordination, there is a wonderful, really positive set of interactions between various agencies. For whatever reason, there is a very strong commitment to working together. He met the previous day with Pamela Hyde, the new SAMHSA Administrator, and they talked about areas in which they can work together. He and Mary Wakefield, the Health Resources and Services Administration (HRSA), Administrator were to speak later in the afternoon.
- ❑ He thanked the tribal leaders for the testimony they submitted, stressing that he does read what he is given, and that he would read and learn from their submissions.
- ❑ In regard to information and training for CDC's own staff, Dr. Frieden is a big fan of e-learning. With the shortage of dollars, they must do things that are more efficient. He did this in New York City, which allowed them to train more people for less money better. He would like to do this with the CDC and to make electronic resources available to whomever is interested. The first thing that he did as the new Director of CDC was to establish a Public Health Grand Rounds, which is typically on the third Thursday of each month. Unfortunately, it is at 9:00 AM, which has been complained about from CDC's colleagues on the West Coast. However, it is archived and available. Each session is approximately an hour and 15 minutes on a cutting edge topic in public health. A host of electronic resources is important.
- ❑ One of the reasons for the organizational change was to emphasize data and policy change. In New York City, Dr. Frieden created a policy called Take Care New York, which identified the key things about which they could do something, and then set measurable goals for trying to deal with that. He stressed that he really appreciated the point that was made about priorities. In fact, within CDC there has been a lot of discussion about this. Instead of talking about priorities, because each program and community will have its own priorities, they talk about winnable battles: What are the things that we know we can do something about, and let's challenge ourselves to accomplish that. He also appreciated the education about community values. One of the things he thought about in preparing for this meeting regarded how burden is prioritized and measured. One of the means in public health has traditionally been a measure known as Years of Life Loss (YLL), which is a simple measure which says that if someone dies at the age of 75, then YLL before age 80 would be 5. If someone dies at the age of 5, that would be 75 YLL. Everyone would probably say that in some ways, a younger person dying is more tragic than an older person dying, yet in communities which revere their elders, perhaps that is not an appropriate way to prioritize.
- ❑ Pertaining to responsibility and blame, which was a theme he heard, Dr. Frieden shared his philosophy. He typically shows a slide of a pyramid that has five levels. At the bottom of the pyramid is the social structure (e.g., education, poverty, housing, jobs, inequality). These are the things that have the biggest impact on health. One level above that are the classic public health programs (e.g., clean water, fluoridated water, et cetera). These are things that change the context so that people would have to really work to not do the healthy thing. One level above that are light touch clinical interventions (e.g., immunizations, colon cancer screening, et cetera), which only have to be done once a year or once every five, but which will have long-term protective effects, so they are easier to do. One level above that is long-



term clinical care (e.g., treatment for high blood pressure, high cholesterol, diabetes, et cetera). These are issues that require on-going, effective clinical care. One level above that are counseling and education—telling people what to do (e.g., eat healthy, be physically active, et cetera). These levels are in a pyramid form because they are roughly in a level of effectiveness of interventions. People can be told to eat less and exercise more incessantly and it will not make any difference, but the structures must be addressed to make it easier for people to do the healthy thing.

Throughout the remainder of the day, tribal leaders offered additional testimony related to the specific topic areas of 2009 H1N1 Influenza: Lessons from Indian Country; Chronic Disease and Environmental Health Topics; and Injuries, Suicide, and Youth / Family / Intimate Partner Violence. In addition, general testimony was offered during open testimony sessions which echoed the themes reflected during the TCAC meeting with respect to major health problems, factors contributing to those problems, and existing / potential solutions. During the session with Dr. Frieden and throughout the day, members of the executive leadership were present and responded to the testimony provided.

Attendant Roster

Tribal Consultation Advisory Committee (TCAC) Members

Chester Antone, Tucson, TCAC Chair (Tohono O'odham Nation, Councilman)
Roselyn Begay, Navajo Nation (Division of Health, Program Evaluation Manager)
Joe Finkbonner, Portland (Northwest Portland Area Indian Health Board, Executive Director)
Reno Franklin, California (California Rural Indian Health Board, Chairman)
Kathy Hughes, Bemidji, TCAC Co-Chair (Oneida Business Committee)
Cynthia Manuel, NIHB (Tohono O'odham Nation, Councilwoman)
Michael Peercy, Tribal Self-Governance Advisory Committee, Choctaw Nation of Oklahoma, Epidemiologist
J.T. Petherick, Oklahoma (Cherokee Nation, Health Legislative Officer)
Alicia Reft, Alaska (Karluk Ira Tribal Council)
Dee Sabattus, Nashville (United South and Eastern Tribes, Inc., Interim THPS Director)
Lester Secatero, Albuquerque (Albuquerque Area Indian Health Board, Chairman)
Roger Trudell, Aberdeen (Santee Sioux Tribe of Nebraska, Chairman)
Derek Valdo, NCAI (from Pueblo of Acoma, National Congress of American Indians)

Other Elected Tribal Leaders

Cathy Abramson, Sault Tribe of Chippewa Indians, Board Member
Candida Hunter, Hualapai, Councilwoman
Joyce Jones, Karluk IRA Tribal Council, Vice-President
Andy Joseph, Jr., Colville Tribes, Northwest Portland Area Indian Health Board Chair, HHS Chair Tribe Council, NIHB
Buford L. Rolin, Poarch Band of Creek Indians, Tribal Chairman

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

Stacy Bohlen, NIHB, Executive Director
Michael Bristow (Osage Tribe of Oklahoma)
Jessica Burger, NIHB, Deputy Director
Bridget Canniff, Northwest Portland Area Indian Health Board, Tribal Epi Center Consortium,
Project Director
Kristal Chichlowska, Colville Confederated Tribes, California Tribal Epidemiology Center,
Director
Alan Crawford (former AI CDC employee)
Feliciano Cruz, Pascua Yaqui Tribe, Public Health Emergency Preparedness Coordinator
Larry Curley, Indian Health Board of Nevada, Executive Director
Elaine Dado, Northwest Portland Area Indian Health Board
Maria Garcia, Pascua Yaqui Tribe, Program Manager Alternative Medicine
Tim Gilbert, Alaska Native Tribal Health Consortium, Senior Director, Community Health
Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center, Director
Lyle Ignace, Coeur D'Alene, Indian Health Service, Medical Officer
Luke Johnson, Fort Mojave Indian Tribe, Public Health Emergency Preparedness Coordinator
Angela Kaslow, CRIHB, Director, Family and Community Health Services
Deborah Klaus, Navajo Division of Health, Director / Senior Epidemiologist, Navajo Epi Center
Steven Matles, Indian Health Board of Nevada, Deputy Director
Jackie McCormick, Northwest Portland Area Indian Health Board
Ruth Ojanen, Board Member, Norton Sound Health Corporation
Michael Peercy, Choctaw Nation of Oklahoma, Epidemiologist
Geoffrey Roth, National Council of Urban Indian Health, Executive Director
Paul Saufkie, Hopi Tribe, Public Health Emergency Preparedness Coordinator
Audrey Solimon, NIHB, Senior Advisor, Public Health Programs
Berda Willson, Norton Sound Health Corporation, Board Secretary

Centers for Disease Control and Prevention

Thomas Frieden, Director, CDC; Administrator, ATSDR
Larry Alonzo, Commander, US Public Health Service
Annabelle Allison, Environmental Health Specialist, NCEH / ATSDR
Ileana Arias, Principal Deputy Director, CDC
Samra Ashenafi, Health Communications Specialist, Global Health
Lynn Austin, Chief Management Official for Terrorism Preparedness and Emergency Response
Mark Austin, Plans Chief, Office of Public Health Preparedness and Response
Aneel Advani, Associate Director for Informatics
Stephen Babb, Public Health Analyst, NCCDPHP / OSH / OD
Mick Ballesteros, Associate Director for Science, National Center for Injury Prevention and
Control
Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion
Holly Billie, Senior Injury Prevention Specialist, National Center for Injury Prevention and
Control
Lisa Briseno, Health Communication Specialist, NCEH / ATSDR Office of Communication
Kristen Brusuelas, Chief of Government Relations, State and Local Services
Ralph Bryan, Senior Tribal Liaison for Science and Public Health
Nick Burton, Public Health Analyst, OD / NCCDPH



Maggie Byrne, Public Health Analyst, NCEH / ATSDR
Jay Butler, Director 2009 H1N1 Influenza Vaccine Task Force
Sabrina Chapple, Project Officer, Wisewoman Program / NCCDPHP
Daniel Chapman, Psychiatric Epidemiologist, NCCDPHP
Pyone Cho, Epidemiologist, NCCDPHP
Monique Colbert, Office of Public Health Preparedness and Response
Janet Collins, Associate Director for Program
Alex Crosby, Epidemiologists, Division of Violence Prevention, NCIPC
Larry Cseh, ATSDR, Environmental Health Scientist
Sean Cucchi, Associate Director for Policy, NCCDPHP
Rob Curlee, Deputy Director, Financial Management Office
Scott Damon, Health Communications Lead, Air Pollution and Respiratory Disease, NCEH / ATSDR
Veronica Davison, Public Health Advisory, NCCDPHP
Lori de Ravello, IH S / Division of Epidemiology & Disease Prevention, Public Health Advisor
Clark Denny, Health Scientists, Birth Defects Center
Bill Dietz, Director, Division of Nutrition, Physical Activity, and Obesity / NCCDPHP
Henry Falk, Director, National Center for Environmental Health / ATSDR
Sherry Farr, Epidemiologist, NCCDPHP
Roseanne Farris, NCCDPHP / DNPAO, Branch Chief
Kevin Fenton, Director, National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Helen Flowers, Science Team Leader, NCEH / ATSDR
Divia Patrick Forbes, NCHHSTP / OD / OHE, Public Health Analyst
Constance Harrison Franklin, NIOSH / OD, Public Health Analyst
Michael Franklin, Senior Public Health Analyst, Financial Management Office
Wendee Gardner, ORISE Fellow, NCHHSTP
Donna Garland, Acting Associate Director for Communications
Larry Gilbertson, Public Health Advisory, NCCDPHP
Wayne Giles, Acting Deputy Director, National Center for Chronic Disease Prevention and Health Promotion
Lauren Green, Health Analyst, NCHHSTP
Yvonne Green, Director, Women's Health
Ingrid Hall, Team Lead, NCCDPHP
Robin Hamre, Public Health Analyst
Tom Hearn, Deputy Director, National Center for Infectious Diseases
John Hustedt, Prevention Specialist
Robin Ikeda, Acting Deputy Director, National Center for Injury Prevention and Control
Sakina Jaffer, Public Health Analyst
Valerie Kokor, Public Health Advisory, Office of Public Health Preparedness and Response
Christine Kosmos, Director, Division of State and Local Readiness
John Krebs, Health Scientist, Vector Borne Diseases
Crayton Lankford, Director, Financial Management Office
Kari Leech, Water Engineer, NCEH / EHSB / Global Water, Sanitation, and Hygiene
Sarah Lewis, Health Communications Specialist, Diabetes Programs
Colleen Martin, Epidemiologist, NCEH / ATSDR
Kathleen McDavid Harrison, Associate Director for Health Equity, NCHHSTP
Judith McDivitt, Director, National Diabetes Education Program
Marian McDonald, Associate Director for the Office of Minority and Women's Health
Matthew Murphy, Epidemiologist, NCEH / ATSDR



Pamela Myers, Surveillance Partners Coordinator
James Nelson, Diversity Officer
Demetrius Parker, Marketing Communications Lead for Cultural Communications
Patricia Patrick, Public Health Advisory
Peter Penny, Procurement Analyst, DHHS/CDC/OD/OCOO/PGO/OPOE
Zina Peters, Health Marketing Communications Specialist, Global Health
Steve Redd, Director, Influenza Coordinating Unit
Bob Ruiz, Acting Director, EEO and Diversity
Dan Rutz, Global Health Communication Team Lead, Center for Global Health
Marjorie Santos, Health Education Specialist, NCCDPHP
Dawn Satterfield, Native Diabetes Wellness Program
Magon Saunders, Public Health Advisor, DDT
Puja Seth, Post-Doctoral Fellow, NCHHSTP
Tanya Sharpe, Deputy Director, NCHHSTP, Office of Health Equity
Arlene Sherman, Committee Management Specialist
Dana Shelton, Acting Director, Office of Health and Smoking
Tom Sinks, Deputy Director, National Center for Environmental Health / ATSDR
Mike Snesrud, Senior Tribal Liaison for Policy and Evaluation
Daniel Sosin, Acting Director, Office of Public Health Preparedness and Response
Stephen Thacker, Acting Deputy Director, Office of Surveillance, Epidemiology, and Laboratory Services
Jennifer Tucker, Team Lead LEG and Partnership, CCHP / NCCDPHP / OD / OP
Myra Tucker, Tribal Liaison
Karen White, Acting Deputy Director, Office of State and Local Support
Lorraine Whitehair, Division of Nutrition, Physical Activity, and Obesity / NCCDPHP
Walter Williams, Office of Minority Health and Health Disparities

Other Federal Guests

Karen Ashton, Executive Officer, Region IV
Admiral Clara Cobb, OS / HHS Region IV Director
Stacey Ecoffey, Principal Advisory for Tribal Affairs, Intergovernmental Affairs, HHS
Ronald Demaray, IH S, Acting Director, Office of Direct Service and Contracting with Tribes
Deric Gilliard, Region IV, Intergovernmental Affairs
Lawrence Shorty, Public Health Advisor, US Department of Agriculture, Office of Tribal Relations

