



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

Tribal Advisory Committee (TAC) Meeting

**February 5-7, 2013
Minutes of the Meeting**



Table of Contents	Page
Acronyms.....	3
DAY 1.....	5
Welcome and Introductions	5
CDC Orientation	5
Tribal Support Update and Discussion	7
CDC Budget	7
TAC Business Meeting	9
Roll Call.....	9
Approve Agenda	9
Federal Advisory Committee Act.....	14
TAC Composition	18
Orientation to the TAC	23
Tribal Consultation Policy Updates	24
TAC Charter Updates.....	25
TAC Recruitment.....	27
Approve Minutes	33
POIR—Performance Organizational Improvement Review	33
Wrap-up of Business Meeting.....	33
DAY 2.....	34
Opening/Welcome	34
CDC Director's Update	34
Moving with Tradition Instant Recess, Fort Peck Assiniboine_and Sioux Tribes.....	37
Roundtable Discussion with CDC Senior Leadership	37
Introduction to Funding Opportunities at CDC	42
Discussion of Collaborative Efforts with_Dr. C June Strickland, PhD, RN	44
(University of Washington): Grant Writing Tutorial.....	44
Closing Blessing	45

DAY 3.....	45
Introduction/Welcome	45
Tribal Support Update.....	46
Update on the Compendium of Stories.....	47
Discussion on CDC Laboratory Specimens.....	49
Moving with Tradition Instant Recess®, Fort Peck Assiniboine_ and Sioux Tribes	52
Traumatic Brain Injury.....	52
Suicide Prevention.....	53
CDC’s National Intimate Partner Violence Surveillance System_ and Intimate Partner Violence.....	55
Diabetes—A Public Service Announcement Debut:	57
Our Cultures Are Our Source of Health	57
Circles of Care and Systems of Care Programs (SAMHSA).....	58
National Institute for Occupational Safety and Health:.....	59
Worker Safety and Health Outreach	59
Community-Based Public Health Engagement.....	62
Wrap-Up	64
Appendix A: Participant Roster	65

Acronyms

ACA	Affordable Care Act
ACES	Adverse Childhood Experience Study
AI/AN	American Indian/Alaska Native
ANA	Administration for Native Americans
ATSDR	Agency for Toxic Substances and Disease Registry
BMI	Body Mass Index
CASPIR	CDC and ATSDR Specimen Packaging, Inventory and Repository
CDC	Centers for Disease Control and Prevention
CRIHB	California Rural Indian Health Board
DFO	Designated Federal Official
EHP	Essential Health Provider
FACA	Federal Advisory Committee Act
FFE	Federally-facilitated Exchange
FOA	Funding Opportunity Announcement
FTE	Full-Time Equivalent
HHS	Health and Human Services
IHS	Indian Health Service
IRB	Institutional Review Board
LSPPPO	Laboratory Science, Policy, and Practice Program Office
MASO	Management Analysis and Services Office
NAGPRA	Native American Graves Protection and Repatriation Act
NALM	National At-Large Tribal Member
NCAI	National Congress of American Indians
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCIPC	National Center for Injury Prevention and Control
NIH	National Institutes of Health
NIHB	National Indian Health Board
NIOSH	National Institute for Occupational Safety and Health

NPHII	National Public Health Improvement Initiative
NPHPSP	National Public Health Performance Standards Program
NVDRS	National Violent Death Reporting System
OCOO	Office of the Chief Operating Officer
OPHPR	Office of Public Health Preparedness and Response
OSTLTS	Office of State, Tribal, Local, and Territorial Support
PGO	Procurement and Grants Office
PHAP	Public Health Associate Program
PHLP	Public Health Law Program
PHPS	Public Health Prevention Service
PSAs	Public Service Announcements
RMSF	Rocky Mountain Spotted Fever
SAMHSA	Substance Abuse and Mental Health Services Administration
STAC	Secretary's Tribal Advisory Committee
STLT	State, Tribal, Local and Territorial
TAC	Tribal Advisory Committee
TASII	Technical Assistance and Service Improvement Initiative
TBI	Traumatic Brain Injury
TSGAC	Tribal Self Governance Advisory Committee
UCLA	University of California, Los Angeles
USET	United South and Eastern Tribes, Inc.
VFC	Vaccines for Children
VSPB	Viral Special Pathogens Branch

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DAY 1

Welcome and Introductions

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

The U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR), held its Winter 2013 CDC/ATSDR Tribal Advisory Committee (TAC) Meeting on February 5-7, 2013, at the CDC Headquarters in Atlanta, Georgia. The meeting opened with TAC Chairman Chester Antone, Councilman, Tohono O'odham Nation, providing the opening blessing.

Dr. Monroe welcomed the group and asked the committee members, followed by other attendees, to introduce themselves (See Attachment A: Participant Roster). She expressed optimism regarding what can be accomplished over the next couple of years if a focus on improving health outcomes in American Indian/Alaska Native (AI/AN) populations is maintained. Dr. Monroe noted that the Office for State, Tribal, Local and Territorial Support (OSTLTS), which houses the Tribal Support Unit, underwent a transition over the last year to align itself with the HHS Tribal Consultation Policy; and she re-affirmed the CDC's commitment to having a government-to-government relationship with Tribes.

CDC Orientation

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

Dr. Monroe discussed the organization of the CDC, highlighting key leadership positions. She noted the importance of the four national centers under the Office of Noncommunicable Diseases, Injury, and Environmental Health: NCBDDD [National Center on Birth Defects and Developmental Disabilities]; NCCDPHP [National Center for Chronic Disease Prevention and Health Promotion]; NCEH/ATSDR [National Center

for Environmental Health/Agency for Toxic Substances and Disease Registry]; and NCIPC [National Center for Injury Prevention and Control], as well as other offices to Tribes. Regarding the OSTLTS, Dr. Monroe discussed the organization of the office, noting that the Division of Public Health Performance Improvement oversees accreditation and the NPHII [National Public Health Improvement Initiative]—aimed at accelerating public health accreditation readiness. She shared the OSTLTS mission; and she discussed the role of Tribal Support Unit Associate Director Delight Satter. Dr. Monroe shared data pertaining to CDC grant awards to Tribes and she specifically addressed the NPHII grantees and their Performance Improvement Managers Network, as well as the NPHPSP [National Public Health Performance Standards Program], which is now housed in OSTLTS. Other highlights from Dr. Monroe's presentation included the following:

- Regarding the National Voluntary Accreditation and Quality Improvement effort, the Public Health Accreditation Board was launched in September 2011.
- CDC has taken on the Technical Assistance and Service Improvement Initiative (TASII), a cross-agency initiative to improve CDC technical assistance to its partners. Evaluation results will be used to make improvements; outcomes include improving project officer recruitment, retention, and job satisfaction, as well as developing more effective workforce development programs, improving project officer competency and service delivery models, and improving satisfaction of external customers with project officer and subject matter expert services and support.
- The Primary Care and Public Health Initiative (whose mission is to help build a stronger linkage between primary care and public health) is trying to match residents with health departments, which could impact Tribes.
- The Public Health Law Program (PHLP), in OSTLTS, is working to improve the health of the public via law-related tools and legal technical assistance to public health practitioners and policy makers in state, Tribal, local, and territorial (STLT) jurisdictions.
- February 5, 2013, is the last day for Public Health Associate Program (PHAP) applications, but that may be extended. Starting in March, Tribes can apply to be a host site. PHAP is a 2-year, entry-level, on-the-job training program that was established to enhance public health capacity.
- PHPS [Public Health Prevention Service] is a 3-year training and service fellowship for master's level public health professionals. It focuses on public health program management, program planning, implementation, and evaluation.
- Activities related to health official engagement include a new welcome packet, official orientation, and focused calls with jurisdictions, among other things.
- The STLT Gateway and other communication tools, e.g., teleconferences, weekly communications, and *Have You Heard?*, are being used to share news, lessons learned, success stories, resources, and information from and to the field.

Tribal Support Update and Discussion

Delight Satter, MPH (Confederated Tribes of Grand Ronde): Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

Ms. Satter informed the TAC that OSTLTS focused its first year on infrastructure building, policy and relationship building, and communications. During that time, OSTLTS expanded Tribal Support staff, utilized details to support special projects, and employed two fellows. She said the team enhanced its communication plan, which will include launching a new webpage in the coming weeks. Ms. Satter also indicated that OSTLTS has completed a strategic action plan and is utilizing a tracking tool to improve data and information sharing. After introducing the Tribal Support team, Ms. Satter noted the activities/items they have been working on: the CDC/ATSDR Tribal Consultation Policy; TAC Issues Tracking Tool; and the TAC Charter. She shared examples of the office's representation within CDC and with external partners; and she stated that a collaborative roundtable held last year yielded the *Knowing Tribal Health* guidance document. Ms. Satter also discussed the OSTLTS' partnerships and technical assistance activities. Notably, she said the office will be hosting a "Working with Tribes" online training and promoting an online training series on grant writing specifically designed for Tribal applicants. Finally, Ms. Satter said OSTLTS was able to fund two national level partners: The National Native American AIDS Prevention Center, and the Southcentral Foundation; and she gave examples of CDC's support of AI/ANs, e.g., Community Transformation grants and CDC career development opportunities.

CDC Budget

Kathleen A. Ethier, PhD: Acting Director, Financial Management Office, Centers for Disease Control and Prevention

Dr. Ethier discussed CDC funding that benefits AI/AN populations. For 2011-2012, she shared allocations of funds that fell into three categories: contracts awarded to Tribally-owned companies or organizations; grants or cooperative agreements to a Federally-recognized Tribe or Tribal organization; and the Vaccines for Children (VFC) Program. In 2012, she said overall funding was over \$220 million to AI/AN programs: 71 percent to VFC; 16 percent to contracts; 12 percent to grants. Dr. Ethier said the level of funding from 2011 to 2012 stayed about the same, with a slight change occurring in the contracts area. She noted that there was a 5 percent reduction in contracts across all of CDC, as a result of an Executive Order to hire more FTEs and not contract staff, but she said they will investigate further which Tribal organizations lost or experienced decreased funding. She also noted that there was an increase in the VFC Program.

Discussion Points

Q: (Michelle Hayward) Can we have this presentation in a bigger font?

A: (Kim Cantrell) Yes.

Q: (Ramona Antone Nez) When can we get an update on the information that can help us understand the differences in the fiscal years?

A: (Kathleen Ethier) I will see what is available for tomorrow's session, but by the next meeting we should have more information.

Q: (Ramona Antone Nez) With the pending sequestration, would you look to see a decrease in FY 2012 or FY 2013?

A: (Kathleen Ethier) It would be a reduction in FY 2013 dollars, so you would see a decrease from FY 2012 to FY 2013.

Q: (Ramona Antone Nez) For VFC, is there an evaluation component that shows protected vaccinations and how they affect Indian Country?

A: (Kathleen Ethier) The program provides free vaccinations for children. They can be controversial, but there have been major public health success stories over the last few years. We can get you more information.

C: (Delight Satter) It's not a competitive program.

Q: (Jackie Kaslow) For the VFC data, are you giving money to Tribal programs?

A: (Kathleen Ethier) The data shows information on children that get the vaccines.

Q: (Jackie Kaslow) So the funds are not going to Tribes?

A: (Kathleen Ethier) The funds purchase vaccines and the vaccines are distributed. The money doesn't go to any organization, it goes to locations.

C: (Delight Satter) We can have specific questions go to the program. Maybe they can do a special analysis for us.

C: (Jackie Kaslow) I'd like to see which States get which portions for AI/ANs.

C: (Kathleen Ethier) We can do that.

C: (Jackie Kaslow) The level of funding for vaccines has increased, but it's hard to see if it has impacted Indian Country.

C: (Delight Satter) The Indian Health Service (IHS) does play a part in the allocation.

Q: (Ramona Antone Nez) How much of the vaccination program funds come from IHS?

A: (Kathleen Ethier) I don't have an answer to that.

C: (Chester Antone) The separation of funding categories has been an issue since I've been here.

C: (Kathleen Ethier) The data reported is our contracting data; it's not State reported.

C: (Chester Antone) But, there is an issue with the classification of kids getting vaccines.

C: (Kathleen Ethier) I will try to get answers on the VFC Program. We need to do more analysis on our data. There is an HHS report that highlights accomplishments related to Tribes. You will see the programmatic work detailed there.

Q: (Lisa Pivec) How do you define an “Indian owned organization?”

A: (Kathleen Ethier) I’ll have to get back to you on that.

Q: (Lisa Pivec) On disease-specific programs, what percentage of funding goes to Tribes? I’d like to see that for cooperative agreements. So, if funding goes up, do Tribal funds go up?

A: (Kathleen Ethier) That is an important point. I’ll see if we can add some clarity to these numbers.

TAC Business Meeting

Chester Antone (Tohono O’odham Nation): Chair, TAC

Chairman Antone facilitated the “Business” portion of the meeting, which was closed to the public.

Roll Call

Kimberly Cantrell, Deputy Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support (OSTLTS), Centers for Disease Control and Prevention, called the roll. The following individuals were present: Alicia Reft, Jay Butler, Cathy Abramson, Michelle Hayward, Jackie Kaslow, Ramona Antone Nez, Lisa Pivec, Chester Antone, and Sandra Ortega.

Approve Agenda

Motion

Ms. Reft motioned to approve the agenda for the February CDC/ATSDR TAC Meeting. Ms. Nez seconded the motion. No vote was taken, as the group embarked on a discussion, deciding to leave the vote until a later time.

Discussion Points

Q: (Michelle Hayward) Do we have a quorum?

A: (Delight Satter) A quorum is a simple majority of those seated. We have 6 delegates; we are recruiting for 10. Every seat is covered, so we have 100 percent representation.

Q: (Michelle Hayward) Where is it written that the seats are vacant or what bylaw states we have a quorum?

A: (Delight Satter) Since August there has been 5 seats, until Cathy Abramson accepted the Bemidji seat. I'm the Executive Secretary; I will always make sure we are following the rules. There is no charter. It expired in 2010; you are an unchartered committee. You can argue there is a charter, which will be addressed on the slides. We can hold off on approving the agenda until after viewing the slides.

C: (Alicia Reft) There is an edge to you that makes me uncomfortable. That is my perception. We are just trying to work together and move forward. There is so much animosity in the room and on the phone. Your attitude is off-putting. I don't feel good about being in this room. Tell me if I'm wrong. I've never felt it until you came onboard.

C: (Delight Satter) I do want you here; I don't mean to be offensive to you. I walked into a position and found the agency out of compliance with the law and the HHS policy. I've tried to correct that. I want to work on our relationship. You are welcome, so I'm glad you said something.

C: (Chester Antone) We will hold off on the motion until we go over the slides.

C: (Alicia Reft) The committee has not been working intentionally out of compliance. To get back into compliance we have to work together. The trust is not there. I think we have to deal with that first. I would like an explanation regarding the people that were removed from the committee.

C: (Michelle Hayward) I don't think we should have had a meeting until we completely got the committee together. I'm not going to be a part of something that is not a quorum.

C: (Delight Satter) It is a quorum.

C: (Michelle Hayward) Then I'd like to see that in writing. We are unauthorized, I feel, to do anything. We have 109 Tribes in California; I'm not here for my Tribe. Nothing went out to all the Tribes in California. It feels like this is up in the air.

C: (Delight Satter) There could have been another approach, but there was a transitional plan being worked on before I came and a subcommittee decided on this plan. Your plan would have been equally feasible. If you are here and you can't take the seat for your delegate, then we'll have to deal with that.

C: (Michelle Hayward) My Tribe will support me, but that is not how I got on this committee. I got here as the Chair of the CRIHB [California Rural Indian Health Board]. I have no letter from my Tribe saying I'm on the CDC TAC. I don't know how I got on here before. I do represent California in many other ways. Dr. Roubideaux sends letters to every Tribe (565 Tribes) asking if they would nominate someone.

C: (Delight Satter) That is more in line with how our process is here, now. Moving forward, we want to follow a similar HHS model, but we had the issue of what to do with those that have been involved for years and grandfather people in that still have an interest.

C: (Cathy Abramson) I appreciate not approving the agenda because we haven't seen in writing the definition of a quorum and I don't know when the closed session started. I don't really feel comfortable with that. Many feel like our input may not be helpful. I believe the best way to handle things is for us to work together. I made a motion to approve the consultation policy at the last meeting, but afterwards I rescinded it; that was in a closed session. That was against Robert's Rule of Order. The voting should have taken place in an open session. I think the discussion today will be helpful to all of us.

C: (Lisa Pivec) I understand the frustrations. I don't represent Cherokee; I represent the Oklahoma area and I got feedback from the other Tribes. One of those was to get clarification on the closed session. As a Cherokee, this was our home for many years. My great grandparents were born here. I feel a responsibility to stand up for our rights. I feel like the Tribal Consultation Policy signage was a violation of our rights. It was my understanding that we would table the discussion and have follow-up conversations. I think we need to develop some trust. As Indian people we have been divided and our relationship with the government contentious. We need CDC in our community to address health disparities.

C: (Jackie Kaslow) I felt strongly that as an alternate, with a newly elected representative, I felt it was important that Michelle Hayward be advised on the decisions being made. I expressed that and I seconded the motion to have the policy rescinded. I was surprised to know it was approved, as I had the same understanding that Lisa had. I feel Michelle Hayward didn't have proper notification of what the charter meant. I would also mention that the procedures to ensure decision makers are well informed and their roles clearly defined haven't been transparent.

C: (Delight Satter) We share the information, on the calls and via the minutes, so maybe it's the mode of communication. If we get new members, we may have similar concerns, so that is something we need to consider.

C: (Alicia Reft) At the last face-to-face meeting, I felt there was a lot of communication. I thought a face-to-face meeting was going to be for the next vote.

C: (Delight Satter) In our mind it was after 3 weeks, following the meeting; so we need to strengthen the communication.

Q: (Alicia Reft) If we don't have a charter, and in our mind we don't have a policy, what is the possibility of it coming back to the table? It is a trust issue.

A: (Delight Satter) I do think the slides will help. It is a conditional approval. The agency moves forward in the process, but you are not the final decision makers. There was not one request for change; it has been executed.

C: (Lisa Pivec) The call that took place after 3 weeks, I was not informed about it; I don't think Jefferson [Keel] was either.

C: (Kim Cantrell) The one invitation that didn't go out was to you, Lisa. It did go to Jefferson. It was my mistake in not sending it to you.

C: (Alicia Reft) The way it was done was not inclusive of the issues the committee had. Others also thought we would address the policy in the next face-to-face meeting. I don't know if there is recourse for that. One of the changes concerned not having meetings on Tribal reservations.

C: (Kim Cantrell) The discussion on meetings on Tribal lands was an HHS government-wide policy specific to meeting space.

C: (Alicia Reft) But, some of the discussion was relating it to the policy.

C: (Delight Satter) It couldn't go into a Tribal Consultation Policy; maybe it was discussed while the Tribal leaders caucused. That is a different thing from the Consultation Policy.

C: (Lisa Pivec) What I'm hearing is that if we want this to work and build trust, it would be more important to get the support than approving the policy on a technicality. It doesn't need much work, the policy, but is it worth Indian Country being unsatisfied? Is this in the true spirit of enhancing Tribal relations?

C: (Chester Antone) Tohono O'odham Nation, in 2007, took a position not to participate because the Director didn't have a policy. Ever since then, we have had a relationship with CDC. More recently, we urged Dr. Frieden to sign the Tribal Consultation Policy. We had our attorney look at it and we asked for consultation by phone; it was granted. I know there are a lot of trust issues now, because of how things were done. I hope that is something we can overcome. I would like to focus on how do we work together to address the issues, get the committee in compliance, and have the CDC help address Tribal issues.

Q: (Alicia Reft) Was the letter from your Tribe and not from you as the Chair?

A: (Chester Antone) I was speaking as a legislative representative, so it came from the Tribe.

C: (Lisa Pivec) I applaud your Tribe for exercising its rights. It feels like the time when the government couldn't get one person to sign an official treaty and then they would find someone else that would.

C: (Alicia Reft) I still want to know how people got removed from the committee; it's surprising that the rest of the committee was not involved.

C: (Delight Satter) We have to know each other to build trust. I think we have activities planned for today which can benefit us and help us get to know each other. There was a subcommittee that worked on the details; and there were webinars and personal calls made regarding removals. The slides will better explain this.

C: (Michelle Hayward) You didn't acknowledge what Alicia Reft said. What CDC did with Tohono O'odham Nation is what should have occurred with all Tribes. Dr. Frieden is supposed to notify all Tribes and that wasn't done.

C: (Delight Satter) It was my advice to Dr. Frieden to do that.

C: (Michelle Hayward) What CDC and the TAC needs to do is to fill the seats first and get the policy out to all the Tribes and get input. Then you will have fulfilled that process. Our Nations are in dire need for CDC to work in our communities, but we need to do this first. I feel like I should go home until this is together.

C: (Ramona Antone Nez) Navajo Nation recognizes the importance of government-to-government relationships. I don't think there was transparency at the last meeting because if there was we would not have the current State of confusion. The minutes indicated that there was a conditional approval and a 3-week comment period. From your perspective, when did the clock start and stop? It was a huge assumption on your part to approve the policy because you didn't get any comments. We will continue to voice our concerns, but is this issue mute? The policy is signed and there is nothing we can do? You will show us the multiple opportunities members had to convey information to Tribes and hold your position that there is nothing that can be done? What are the options for putting a stop to the signature of Dr. Frieden? How is he going to address what is really on our minds about this policy? The HHS policy talks about having to identify a clear conflict on the table; I have concerns about committee composition, the selection process, and other things. At Mohegan, it seemed like we were approving the policy and the charter. Because the policy is signed, did that affect the charter? Now we are an advisory to you and you determine who sits at the table? I have multiple concerns.

C: (Alicia Reft) If the policy stays, I think we are here just for show and you don't really care what we say. This will not end here if the policy doesn't come back to the table. It might not seem big to you, but it's huge to our people.

C: (Cathy Abramson) In looking at the minutes, it needs to be said that when we voted it was a closed session and we wanted to rescind the motion. The way the minutes are presented, it looks like we approved it. There is nothing that speaks to our issues or the

fact that it was a closed session. As far as I know, you can't vote in a closed session. I want to go through the slides because you say it will answer some of our concerns. I don't think everyone wants to get to know each other right now.

C: (Delight Satter) HHS-wide, all of the TACs are struggling to have full seats. IHS has been in this business a lot longer. We are all trying to be responsible to the IEA [Office of Intergovernmental and External Affairs]. We are all trying to improve. Your goals are our goals. If we only meet twice a year, how can we work over the year to make progress? CDC is very community-based, but the model has to be tweaked. I hear the concerns. We have 15 minutes before our speaker comes in to speak about the Federal Advisory Committee Act (FACA). Cathy, there are two sets of minutes, so you might find the information you are looking for in the other set. I did want to introduce the new staff. Also, it's not in your protocol to follow Robert's Rules, you kind of just do it.

Q: (Sandra Ortega) I'm new here. I understand the concerns expressed. Communication is a big problem and also the best solution. How do you schedule your conference calls? On another committee, we have a set time every month to have a call. Our people are not an excuse. A lot of CDC and IHS people are the very reason we sit here. We should not give up on anything. We have a right to disagree and get upset. It's important that what has been shared today gets communicated. You have communicated; you are at the table today. That's what your people should be proud of.

Q: (Ramona Antone Nez) On committee composition, our partners that were on the board (NIHB [National Indian Health Board], Self Governance, etc.) that had a seat in August 2012, are they officially removed now?

A: (Delight Satter) The seats were dissolved. That's why we had the transitional plan. Seats to organizational entities are not allowed; it's out of compliance with Federal law and the HHS Tribal Consultation Policy. Their seats will have to be spoken through one of the area members. There are other CDC advisory committees they can participate on. Jefferson [Keel] has elected to have an authorized representative from another Tribe. Any nonprofit or other entity can serve in the second seat, so they can participate in that capacity.

Federal Advisory Committee Act

Gladys Lewellen, CM/Lead Committee Management Specialist, Management Analysis and Services Office, Office of the Chief Information Officer, Office of the Chief Operating Officer, Office of the Director, Centers for Disease Control and Prevention, provided the TAC with an overview of the FACA. She explained that FACA provides legal framework for establishing Federal Advisory Committees. Her presentation covered the congressional intent of FACA; oversight and management of advisory committees; establishment, role, and membership of such advisory committees; advisory committee meetings, subcommittees, and workgroups; and communication of work products. Among the notable items she cited included the following:

- New advisory committees are established only when they are determined to be essential and they terminate when they have fulfilled the purpose for which they were established.
- Federal Advisory Committee membership includes special government employees (private citizens), ex-officio members, and liaison representatives.
- Meetings require public notice and opportunity for public comment.

For FACA exempt committees, Ms. Lewellen said certain criteria must be met. To that end, she stated that “FACA shall not apply to actions in support of intergovernmental communications where: 1) meetings are held exclusively between Federal officials and elected officers of State, local, and Tribal governments (or their designed employees with authority to act on their behalf) acting in their official capacities; and 2) such meetings are solely for the purposes of exchanging views, information, or advice relating to the management or implementation of Federal programs established pursuant to public law that explicitly or inherently share intergovernmental responsibilities or administration.”

Discussion Points

C: (Delight Satter) As the Designated Federal Official (DFO), I started to see there was a problem. I also understand that the issue of membership had been raised previously. A discussion with members yielded the development of a subcommittee to deal with FACA, to make the needed corrections. It has been a year of transition.

Q: (Michelle Hayward) So we don't have to abide by FACA?

A: (Gladys Lewellen) No, because you are exempt.

C: (Delight Satter) The purpose of the committee is to hear from Tribes, so it makes sense that we have to have elected officials. If you were not an elected official, you can't serve as a delegate. There were four seats that were given to nonprofit organizations; that can't happen.

Q: (Michelle Hayward) How did CRIHB get here?

A: (Delight Satter) That had to do with a secondary issue. The selection of the delegate was through an expired charter that was outsourced. The selection would be provided by the Indian Health Boards, as if all Tribes were members. That's why we created the subcommittee. They figured out a way that every Tribe has an opportunity to throw in their hat. We were out of compliance; so that's what we are trying to correct.

Q: (Michelle Hayward) You said the charter is expired, is that correct?

A: (Delight Satter) Yes, you can't have a charter without a policy. When the policy expired in 2010, the charter expired. They can be updated at any time and the process of implementing them is pretty easy.

Q: (Michelle Hayward) Why would we let it expire? Why wouldn't it stay in place?

A: (Delight Satter) It's just the Federal process. If you don't have a policy then you don't need a charter. When I came in, both the policy and the charter had been worked on for 2 years. We went through a couple of rounds of revisions and then it was ready for action at the Mohegan meeting in August. The Federal law had not been addressed and it had not been aligned with the HHS Tribal Consultation Policy.

C: (Judith Monroe) From my perspective, when the HHS signed its policy, the agencies were asked to align with it. Over the past year, we have been trying to come into compliance.

C: (Kimberly Cantrell) OSTLTS is 3-years old. Tribal Support previously was not an office. With OSTLTS, the transition has started to happen.

C: (Judith Monroe) We are trying to get it right.

C: (Michelle Hayward) It's a shame that all of the hard work didn't get distributed throughout Indian Country. I hope the policy gets suspended.

C: (Chester Antone) I hope it doesn't get suspended. Without it, at CDC, Tribes fall through the cracks. In the past we would meet, but nothing got done. We voiced our testimony, but nothing happened. Since 2007, they've asked Tribes for testimony. We provided it and never got feedback. Now we can get feedback, because of the policy. We can get formal feedback to issues raised.

Q: (Judith Monroe) Should communication be done through Dear Tribal Leader letters? We want to improve our communication.

C: (Lisa Pivec) We have become selective in using Robert's Rules of Order. Please, let's have Chairman Antone recognize people to speak. Every TAC representative, minus Chairman Antone, is uncomfortable with the process that happened. You can go on a technicality, that you did it right, or do it so that Tribes are comfortable. Many Tribes feel like they didn't have the ability to give input. It's a matter of trust. Ramona asked a question, we want to know if it's going to stand no matter what this group says.

C: (Alicia Reft) When the policy came up for review and changes were discussed, we were told it was not to go out to the Alaska Tribal Health Board. In the last information for this meeting, it said it was for TAC members only. I didn't see anything on an Executive session, so that needs to be clarified.

C: (Delight Satter) There may be items that we share in the slides that may be sensitive. It's also so we can have this trust building conversation.

C: (Michelle Hayward) You say not to share; we have a duty to tell our people what is going on. You need to be clearer. I'm going to share everything that I know and I'm giving it to all 109 Tribes in California.

Q: (Judith Monroe) You are asking that the policy be sent out to all Tribal leaders via a Dear Tribal Leader letter?

A: (Lisa Pivec) Yes.

A: (Cathy Abramson) Yes.

C: (Ramona Antone Nez) I recommend that you follow Yvette Roubideaux's model. She communicates via Dear Tribal Leader letters and keeps them on record on her blog site. It alerts the communities of Tribes and allows an adequate amount of time to be responsive to an issue. Her staff has been open if we need a couple more days to respond. She then cites the concerns submitted. I recommend that CDC implement such a mechanism so the documents can be accessed online to improve communication.

C: (Cathy Abramson) A few years ago I attended a consultation on "consultation." You can send out a Dear Tribal Leader letter and it might stay in that office. I recommend you do the letter and put it on your webpage. All of our Tribal leaders don't have health as their main topic. Another recommendation is to send a copy to the health directors.

C: (Lisa Pivec) I agree with those recommendations. I attended the Oklahoma area IHS consultation. Dr. Roubideaux joined us via satellite. CDC doesn't have the experience of IHS; I recognize that. The message I want to share is Tribes will not be happy until they have had time to review the policy.

Q: (Delight Satter) Can you share the comments on trust you mentioned earlier?

A: (Lisa Pivec) I said this feels reminiscent of times when the Federal government would say, "You didn't comment or read it correctly" and they would just move forward. It also felt like when the government couldn't get John Ross to cede our lands and so they found someone who would. As a result, our Tribes were moved across the country and divided. When we come together as a body and someone supports it, that doesn't speak for everyone. I need to be able to say they have had ample opportunities to comment and then I can defend the policy.

C: (Judith Monroe) Thank you for the advice, it's something we can put into action. We can try to do the Dear Tribal Leader letters. We've talked about sending the Consultation Policy out and I see no reason we can't do that. I would also say I'm sorry for the miscommunication. It's not our intent to have distrust in the relationship. There are so many scientists and social servants that want to see improved health for AI/ANs. They care deeply about Native populations and many others want to be involved.

C: (Chester Antone) I want to clarify that CDC did not approach us to approve the policy; it came solely from me.

Q: (Ramona Antone Nez) Part of the discussion earlier was about the process of how this policy was signed. The version that I have is that Dr. Frieden signed the policy on January 8, 2013. In this case, there are some concerns that I shared. It seems at the last meeting the committee passed the policy and then rescinded it 2 days later. The

part that is unclear is the calls and who voted on the call. Because there was no written document provided, the assumption was everything was okay with the committee. My question is about tomorrow's meeting with Dr. Frieden. I understand he will provide updates and financial data, but one of the things on my mind is the policy. Is there a mechanism to continue to edit the policy or put a stop to it? Do we have to move forward and get over it? To have feelings of historical trauma makes it difficult to move forward without having trust. It seems like our voices were not heard.

A: (Judith Monroe) Going forward, I believe the next step is to send the policy out to Tribal leaders via a Dear Tribal Leader letter.

Q: (Ramona Antone Nez) So, is Dr. Frieden willing to listen to Tribes?

A: (Judith Monroe) My advice will be to send it out and see if anything comes back. If something comes back substantial, then we'd have to consider that. I completely hear what you have said today and I think that was a big misstep there. I'll have to discuss with Dr. Frieden what to do if we get substantial comments.

C: (Cathy Abramson) If you email the Dear Tribal Leader letter to us, we will know that it has gone out.

C: (Delight Satter) We intended for it to go out. It wasn't at our level that a decision was made for it not to go out.

C: (Michelle Hayward) There is a letter to Dr. Frieden from the NIHB (representing 12 areas) with concerns on the Tribal Consultation Policy, asking that it be suspended until it goes out for Tribal feedback. They want to ensure that all members seated on the TAC can participate, unless a new member has been appointed. I would urge you to talk to Dr. Frieden about this. When you do nominations, you should look at how Dr. Roubideaux did it in her Dear Tribal Leader letter.

C: (Delight Satter) The staff will present on this today and take recommendations; this is just a draft.

C: (Cathy Abramson) I was hoping to get a written response to NIHB's letter.

Q: (Cathy Abramson) Did we go over the definition of the at-large positions?

A: (Delight Satter) I have a slide on that.

TAC Composition

Ms. Satter discussed the composition of the TAC with the group. To assist TAC members in understanding the previous versus current membership, Ms. Satter directed their attention to the composition matrices in the meeting binder. The first chart displayed the TAC composition at the last TAC meeting in August 2012. She noted that the first action towards bringing the committee into compliance was dissolving the seats held by Direct Service Tribes; NCAI; NIHB; and TSGAC [Tribal Self Governance

Advisory Committee]. Those seats were made at-large seats. Ms. Satter proceeded to show the current TAC composition.

Discussion Points

Q: (Michelle Hayward) Was a letter sent to the Bemidji area?

A: (Cathy Abramson) Our Chairman signed the letter.

Q: (Michelle Hayward) You just asked Cathy if she wanted the seat?

A: (Delight Satter) Yes. For those that were active members and elected officials, they were grandfathered in.

Q: (Ramona Antone Nez) Were the four seats that needed to be resolved noted in the teleconference minutes?

A: (Delight Satter) Yes, but not everyone calls in and not everyone reads the minutes.

Q: (Cathy Abramson) Who makes up the policy committee?

A: (Delight Satter) Dee Sabattus, Rex Lee Jim, Chester Antone, Connie Hilbert; it's in the minutes.

Q: (Ramona Antone Nez) Vice President Jim volunteered to be on the committee, but was he active?

A: (Delight Satter) We have attendance records. He wasn't that active, but we meet frequently in D.C. so he was aware.

C: (Alicia Reft) Maybe there should be something in place that other committee members should be notified when changes to the committee are made. It's a respect issue. It's the way it was done that's troublesome.

C: (Delight Satter) We thought we were doing everything right by doing the phone calls; and elected officials were asked to serve in the delegate seat. In the case of Portland, we were thrown a bit because Brenda Nielson was not an elected official. This is sensitive stuff. We were not hearing back from her or Lester Secatero. She could have been an authorized representative. Lester told some CDC staff that he was retiring, but we learned he is not an elected official and his group is not a recognized local government of the Navajo Nation. He could get a delegate and then go into an authorized representative position.

Q: (Cathy Abramson) If I'm an at-large member, I could appoint an authorized representative and have my Tribal Chair do a letter of support for the person?

A: (Delight Satter) You could appoint the person.

Q: (Cathy Abramson) So, I could write a letter from a different Tribe?

A: (Delight Satter) Yes. Kimberly will cover how to do the letters.

Q: (Ramona Antone Nez) How do we fill the at-large seats?

Q: (Cathy Abramson) So, the delegate needs to be an elected or appointed Tribal leader and the authorized representative can be anyone?

A: (Delight Satter) Yes. They do have to be knowledgeable about Tribal matters and the letter must state that they are authorized.

Q: (Cathy Abramson) Does CDC have to approve them?

A: (Delight Satter) Whoever the delegate is, they select the authorized representative.

Q: (Cathy Abramson) Will travel be provided for the delegate and authorized representative?

A: (Kimberly Cantrell) We have dollars set aside to support both meetings. We can travel 16 people to each meeting. We paid for alternates for this meeting because we didn't have all of the seats filled.

Q: (Ramona Antone Nez) So, you set aside funding for delegates for two meetings. If the Nation wants to send an alternate/authorized representative, then that is possible?

A: (Kimberly Cantrell) Absolutely.

Q: (Ramona Antone Nez) So, how are the at-large vacancies going to be advertised?

C: (Jay Butler) The movement away from alternates to authorized representatives changes the dynamic. We feel we both represent Alaska Tribes. This setup works better for us. It's just something I wanted to point out. I wanted to make sure that was intentional.

C: (Delight Satter) Thanks, that is helpful.

C: (Alicia Reft) It will be important for us to state the format of the meeting and if we follow Robert's Rules.

C: (Delight Satter) So, the old and current format is movement through consensus. A vote is only required when there is no consensus, in which case majority rules. That kind of process can be at the charter level.

C: (Chester Antone) At the STAC [Secretary's Tribal Advisory Committee] we define how the meetings will run. I think how we run the meeting and the rules we implement needs to be discussed.

C: (Jay Butler) Although we like the informality and ease of communication, it's good to have the documentation. As an example, a comment was made that removal of the four seats was approved by this group, but the looks around the table indicate that wasn't the case.

C: (Delight Satter) There wasn't an approval; we informed you that it was happening.

C: (Alicia Reft) A courtesy would have been to let us know, saying who was there and who was not going to be there.

C: (Delight Satter) The decision to remove the four seats was a requirement.

C: (Alicia Reft) A letter to the rest of the committee would have been helpful; and your comment that we agreed to the removal was not correct.

C: (Cathy Abramson) The Robert's Rules of Order is fine with me, but for the minutes, there is indication of motions. We didn't follow Robert's Rule because we rescinded it.

C: (Michelle Hayward) I'm almost dumbfounded that you said we can do anything we want to. We can follow or not follow Robert's Rules. We can make a motion at any time. Everyone is watching us right now. I don't want any part of this until this is together and everyone has something to go by and you can prove a quorum. I don't know what I'm going to tell all of my Tribes. You've done business for how many years and you don't even know if you've done it right? I'm going to excuse myself. I think you've disrespected all of us, not even paying attention, checking your phone. I'll come back tomorrow. Everything is illegal; I don't know how you can even do business. I'll have my input tomorrow, until you replace me.

Q: (Ramona Antone Nez) Did you say you and Dr. Holzman decided to "go with it" because you felt our feelings were running high? It didn't matter that we rescinded the motion because we don't have a policy or a way to conduct a meeting anyway? Can you restate that?

A: (Delight Satter) After the Tribes caucused, I thought some Tribes were using rules they use in their Tribal caucuses. There was a sense of heightened anxiety. We were told there was concern about voting taking place in a closed session. I checked and there were no Robert's Rules in effect. On day one, you approved the charter; so we thought it was not appropriate to say that the process of rescinding it didn't stand. You had decided the Chair would review any non-substantive errors. The Tribal Consultation Policy and the charter go through the MASO [Management Analysis and Services Office] process.

C: (Alicia Reft) At that meeting, after the motion was made and seconded, then there was a motion made to rescind it. There was no discussion on the Chair getting details on wording. That was right after the vote that day. Once we found out the closed session was being recorded, that's when we put it on the record.

C: (Ramona Antone Nez) From that meeting, you are saying that rescinding the motion didn't stand. So, that tells me all along it was going to be passed, regardless.

C: (Delight Satter) In the minutes, you will see, we restated the motion of conditional approval with a 3-week review period. It was a bizarre point in time, because Cathy made a motion and she wasn't technically a member. Clearly the new delegates wanted additional time to review things, but nobody submitted requests for changes.

C: (Cathy Abramson) If I wasn't a member and if I made a motion, then it never happened. It totally nullifies that motion.

C: (Alicia Reft) Then everything should be taken back.

C: (Delight Satter) On day one she was a seated member.

C: (Lisa Pivec) My understanding was we would have a call and discuss the issues. I called J.T. [Petherick] and he said he didn't agree to that kind of charter. The charter was the real problem, because it's crucial to the membership. After we voted, then Cathy wasn't a member. It was very confusing.

C: (Alicia Reft) I remember asking where it says we could vote in closed session and Delight, you said it was in the charter. The charter doesn't state that. It wasn't in there. There was miscommunication, but I think you should go ahead with the plan to send it out to the Tribes.

C: (Delight Satter) We are trying to execute FACA exemptions and the rules and be in alignment with HHS' Tribal Consultation Policy.

C: (Cathy Abramson) The HHS policy trumps anything underneath it.

C: (Chester Antone) It is under review again, so let's see if it's working or not.

C: (Delight Satter) I understand Michelle's frustration in not having a framework; I hope you guys will hang in there with us.

C: (Jackie Kaslow) I want to remind CDC that our elected officials are like mayors and for policies not to be in place seems like a trap to them, as it's not official business and it doesn't feel appropriate. Ms. Hayward would like to come to take care of business and it can look dangerous to those that have not been here. If some structural framework can be put in place, then you will have more Tribal leader by-in. If Cherokee and Navajo Nation leaders were here, they may have had the same reaction. The way the policy was handled is very problematic.

C: (Lisa Pivec) It needs to be made clear that if it is sent out as an approved policy, it will not be received well. It has to be sent out as a draft, so Tribal leaders are not viewed as an afterthought.

C: (Chester Antone) We are tasked with having these discussions, regardless of the disagreements. The charter should go out for feedback and feedback from Tribes should be considered. I'm really grateful that we have this TAC. Committees take a lot of work. We are working on having better Tribal relations. We need to use the FACA exemption and hold the CDC accountable. We should also think about the authorized representatives and make sure they have the authority to act/make a decision.

C: (Jackie Kaslow) Passions run high and it shows the magnitude of importance the CDC has in Indian Country. Hopefully we can get some of the solid framework in place. We are hopeful to have progressive, productive work and not get stuck on some of the challenges we have been faced with. If CDC reflects on the reactions thus far, hopefully it will make the right decision regarding the policy.

C: (Lisa Pivec) I see it as my responsibility to take issues to my area and discuss the policy and facilitate the gathering of information. I'm willing to accept that responsibility so I can be assured that my area is represented.

C: (Cathy Abramson) Dr. Frieden received a letter from the NIHB that I signed. Other Tribes have also expressed concerns. In the Bemidji area, Kathy Hughes was originally on the committee and Reno Franklin was also on it at one time. My first day of attendance there was working on the charter and NIHB was within that. To this day, I still don't know the history of the charter or our consultation. In the spirit of cooperation, we can move on.

C: (Jay Butler) If there is going to be a letter going out to Tribal leaders, we need to look at letters already received from Tribes. I wouldn't want anyone angry because they get a request for comments when they have already given comments with no response.

C: (Delight Satter) There is something in the old charter. We have to be careful about separating NIHB from the language. They were listed as the contractor and given a seat; so when you are here you have to wear your Tribal hat or your authorized representative hat. Every piece of advice the CDC got and took action on is open to lawsuit when the committee is not in compliance.

C: (Jay Butler) We understand. My advice is that CDC not be silent on the NIHB letter, but acknowledge receipt and your understanding of the issues and then seek Tribal input.

C: (Judith Monroe) I thought Dr. Frieden had responded, maybe the letter is caught up.

Orientation to the TAC

Ms. Cantrell addressed the issue of the TAC orientation by first discussing the purpose of the advisory committee. She stated that intent of the committee is to identify priorities and exchange views, information, or advice with regard to the management or implementation of CDC/ATSDR programs and initiatives. She explained that the name of the committee was changed 2 years ago from Tribal Consultation Advisory Committee to Tribal Advisory Committee; and she reviewed the core functions of the group. Among those functions include identifying evolving issues and barriers to access, coverage, and delivery of services to AI/ANs related to CDC/ATSDR programs; and proposing solutions and recommendations to address issues raised at Tribal, regional, and national levels. Finally, Ms. Cantrell discussed vehicles for accomplishing

the TAC's work, as well as the responsibilities that come along with being a TAC member, e.g., attend in-person meetings, participate on conference calls, and gathering and disseminating information or relevant issues.

Discussion Points

C: (Delight Satter) Decisions are made and input is solicited on the conference calls, so please participate.

C: (Jay Butler) Less frequent calls at a convenient time would be useful.

C: (Kim Cantrell) We can query everyone on the best time to have the calls.

C: (Jackie Kaslow) We've had a hard time obtaining meeting minutes. CDC should have minutes out in a timely fashion and create a tool that we can use at our meetings to highlight essential work.

C: (Kim Cantrell) We've been talking about providing PowerPoint presentations. We are fixing the problems with the minutes. One issue is they aren't approved for six months, until the next meeting. The conference call minutes are available by the next call.

C: (Jackie Kaslow) People will pay more attention to the minutes from the face-to-face meetings. It's important to have the information disseminated in a timely fashion.

C: (Kim Cantrell) We will work on the best way to communicate the information.

C: (Cathy Abramson) It would be nice to get summary sheets of the meetings.

Tribal Consultation Policy Updates

Ms. Satter requested that the TAC review the process for the Tribal Consultation Policy (provided in the meeting materials) after the meeting so they could have a follow-up discussion on a Monday teleconference call. She said CDC received hundreds of comments on the document, which were incorporated into the final version. She said the changes were both structural and procedural in nature. Ms. Satter also addressed the revision process for the Tribal Consultation Policy. In closing, Ms. Satter shared a timeline of activities, noting that June 2012, was the last time changes came in.

Q: (Cathy Abramson) If the OCOO [Office of the Chief Operating Officer] doesn't agree with what we advise, can they make changes?

A: (Delight Satter) Yes.

Q: (Cathy Abramson) Were their changes sent to us?

A: (Delight Satter) Nothing changed the intent of the policy, it was really legal language. Chester, as the Chair, did see those changes. One term in the glossary was also deleted.

Q: (Lisa Pivec) Before it was implemented, who said the policy should not go in the Federal Register? Also, was Dr. Frieden aware that your recommendation was for it to go in the Federal Register?

A: (Judith Monroe) The Division of the Executive Secretariat said it was not the process for a policy of this nature. This morning's feedback on how Dr. Roubideaux sends some things out was helpful.

C: (Delight Satter) These were standard procedures, which were revised since the Mohegan meeting. The policy could have been signed by OCOO and not required by Dr. Frieden. We reviewed the Tribal Consultation Policies of other agencies and they didn't publish them through a Federal Register Notice.

TAC Charter Updates

In her presentation on the TAC Charter, Ms. Satter emphasized the need to have a focus on recruitment. She said delegates must be elected Tribal officials acting in their official capacity, with authority to act on behalf of the Tribe, and qualified to represent the views of the Indian Tribes in the respective area from which they are nominated. Authorized representatives may be an elected Tribal official or designated Tribal official that is qualified to represent the views of the Tribes, e.g., Tribal health officers, leadership of regional and national nonprofit corporations. In total, Ms. Satter said there will be 12 IHS area delegates and their authorized representatives, and 4 at-large delegates and 4 authorized representatives. In terms of revising the charter, she said the document was edited, the administrative language updated, appropriate language adopted from the STAC's charter, and the document reviewed to ensure compliance with the FACA exemption. Ms. Satter walked the group through the revision process, noting that since June 2012, there have been no requests for changes to the charter that could be made and no submitted comments (just questions on FACA).

Discussion Points

C: (Cathy Abramson) On behalf of NIHB, I wrote a letter. You said it will be answered, but I would appreciate if someone could come to our board meeting and explain the changes related to NIHB. As the Chair of NIHB, I think that would be important.

C: (Delight Satter) We can certainly do that.

Q: (Chester Antone) What is the next step?

A: (Delight Satter) Legally, if there is no rescission, then the conditional approval stands; or you can make a motion to reaffirm it now. It's flexible because the charter can be updated at any time.

C: (Cathy Abramson) The best thing is for Tribal leaders to give input on both the charter and the policy.

C: (Delight Satter) It was never in our plan to give the charter to the Tribes.

Q: (Jackie Kaslow) It's really only one option you gave; I think we want to ensure true input from the broader Tribal community, which means to put out a confirmed policy that is open for revision. Does that present any pitfalls? It can be subject to change if substantive comments come back. Would it go through the entire process again?

A: (Delight Satter) Yes, only if substantive comments are received.

Q: (Jackie Kaslow) Is there any concern about a public comment period?

A: (Judith Monroe) For Federal agencies like CDC, the Tribal Consultation Policy is not required to go into the Federal Register for public comment; that was a point of confusion.

C: (Jackie Kaslow) So, the term "public" is perhaps not the best word. There is an assumption that this committee represents all 500 plus Tribes. You could keep it open for a couple of weeks.

C: (Judith Monroe) When something rises to a level of public comment in the Federal Register, I need to see how the timeframe for comments differs from a Dear Tribal Leader letter request for comment.

C: (Delight Satter) As Ken Lucero stated at the STAC meeting, any Tribe can go into official consultation with any Federal agency. Back to the charter question, I'll have to check to see if the charter could go out for comment, perhaps via Dear Tribal Leader letter.

Q: (Jackie Kaslow) Is the charter contingent on having a policy in place?

A: (Delight Satter) Yes, they are connected. We'll have to be careful with our communication, because they are easy to confuse.

C: (Chester Antone) The charter exists because of the policy, so I see it as internal to the membership. I don't think the STAC's charter was put into the Federal Register. Even if you put the Consultation Policy in the Federal Register, the comments will be different—because they will be related to the CDC consultation. Also, I found the Robert's Rules of Order in case anyone wants a copy.

C: (Cathy Abramson) If anybody knows the history of NIHB in the charter, I would like to hear it.

C: (Chester Antone) It has been in there for a long time.

C: (Cathy Abramson) There is a request to keep it the same; so I think we need an explanation. Maybe that can be answered in a letter. We offer an invitation for someone to come to an NIHB meeting to explain this.

C: (Alicia Reft) I don't see where it says how many seats there are in the Charter.

C: (Kim Cantrell) In the binder is the revised charter. They both say a quorum exists with the simple majority of the seats that are filled.

C: (Delight Satter) The key is to get in alignment with HHS and do your best to follow the guidelines accordingly. We need advice from all of the regions. We need to work on recruitment. Now, we will have a public process for recruitment. We are following the HHS STAC's process for membership.

Q: (Ramona Antone Nez) In the charter, are you (Delight) the person that is the Executive Secretary?

A: (Delight Satter) Yes.

Q: (Ramona Antone Nez) So, you have the responsibility to ensure the committee composition is in compliance, as well as removing people that are not in compliance?

A: (Delight Satter) Yes, all the administrative duties are in my purview; and Kim [Cantrell] is your point-of-contact for letters.

Q: (Ramona Antone Nez) For the four at-large positions, who is eligible and how will they get in? The national organizations that had a seat no longer do; is it possible to have them back on? If so, how do we do that?

A: (Delight Satter) They can't be delegates, but they can serve as an authorized representative. The next presentation on recruitment will address the at-large seats.

TAC Recruitment

April Taylor, MHSA, Public Health Analyst, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention, discussed the issue of TAC recruitment. She said notifications to appropriate entities (e.g., Tribal, regional, and national organizations; Native-serving organizations; and CDC/ATSDR's HHS partners) will be notified of vacancies and solicited for nominations by the CDC/ATSDR Associate Director for Tribal Support. She said names of each TAC delegate and authorized representative are to be submitted to the Executive Secretary in an official letter from the Tribe. Ms. Taylor indicated that the CDC/ATSDR Associate Director for Tribal Support and senior leadership will be responsible for selecting and finalizing the body of members. Finally, Ms. Taylor outlined the priority that will be given to the nominations.

Discussion Points

Q: (Jackie Kaslow) Does there need to be an official letter from the Tribe for the delegate and the authorized representative? Nowhere does it say how you resolve if you have multiples nominations of the same type?

A: (Delight Satter) It will go to the most senior nomination.

Q: (Jackie Kaslow) How would you resolve it if all the nominations have equal rank?

A: (Delight Satter) If they are equal rank, then the letters of support would be considered; and then senior leadership and I will make the decision.

C: (Jackie Kaslow) The potential for a delegate in California has never been widely publicized, so it's conceivable that more than one person equal in standing could be presented to you. The Indian Health Board has a broad constituency, but it's less likely that a small Tribe will advocate for another Tribe to represent them. This is the part that needs to be transparent; this is why we need to send the charter out. In California, you could have an elected official representing 39 Tribes.

C: (Chester Antone) For the STAC, because there are two Tribes in my area, I'm the primary because my Tribe nominated me. They left the alternate position open for the other Tribe. Right now, I don't currently have an alternate. As I understand it, on the CDC TAC, the elected official can select the authorized representative.

C: (Cathy Abramson) Either a Dear Tribal Leader letter went out for STAC membership or another kind of correspondence. One of our STAC members nominated me and our Chairman approved it. My nomination was submitted and I think I got on because they didn't want people with just IHS experience. I think that's why they are saying the letters of support are important.

C: (Jackie Kaslow) In California and Alaska in particular, there is the potential to create disparity and narrow the voice at the table; so I'm concerned that there is not concession for a broader base of representation. That would occur if we have a person from a professional Tribal organization be a representative. The fact that it has to come from the elected Tribal official or Tribe is problematic.

C: (Jay Butler) We have organizations to bring messages forward and this seems to subvert that, making every Tribe an individual.

C: (Delight Satter) The Federal government can't direct an elected official on whom to designate. How will we ensure we hear from more voices? I know what you are saying, but we can't direct them as to whom they should authorize.

C: (Jackie Kaslow) I'm not suggesting that at all. The way the language is written you are disaggregating a voice. You have a limited, narrow perspective for some geographical areas. I'm suggesting the language is narrow in that a Tribal delegate might have difficulty selecting their authorized representative from someone other than their own Tribal enrollment, as opposed to a professional body that could bring other voices to the table through their contacts.

C: (Lisa Pivec) There is some language in the STAC [Rules of Order] that is helpful in terms of our at-large positions. It says, "In order to achieve the broadest coverage of HHS-related national perspectives and views, a NALM [National At-Large Tribal Member] must be qualified to represent on national and collective Tribal perspectives. Representation of such viewpoints includes groups like the National Congress of American Indians, National Indian Health Board, Tribal Self Governance Advisory

Committee, Direct Service Tribes Advisory Committee, National Indian Child Welfare Association, National Indian Head Start Directors Association, and the National Tribal Environmental Council.”

C: (Cathy Abramson) There was no alternate for Bemidji and Tribes submitted nominations; MASS wrote a letter of support, so letters of support are important. The person that got on is a Tribal leader and a health director.

C: (Delight Satter) We made sure our language was an improvement over the HHS language.

C: (Cathy Abramson) According to the Rules of Order for the STAC, one of the people would be considered; but the Tribal leader would have to get a Tribal letter and then letters of support could be given from a health board or other group.

C: (Jackie Kaslow) The spirit of the language is that the person being recruited has presence in a larger body of Tribal representation. They have exposure or presence in forums outside of their own Tribe. I find that to be more robust than what I see in the CDC charter.

C: (Delight Satter) We are hoping to get input from many Tribes on all of the hot topics from their area.

Q: (Cathy Abramson) How do you get the regional health boards, NIHB, to know that the at-large positions are open?

A: (Delight Satter) We have heard reports that Tribes wanted to serve on the TACs and they weren't publicized. We have some draft letters written by the Policy subcommittee under tab 8. This is the draft letter based on IHS' recruitment letter. We are competing against other committees for membership.

Q: (Lisa Pivec) You are using IHS areas for geographic purposes only; that is the confusion. So, if you get nominations from the Oklahoma area from four different Tribal nations, and one came from the health board, will that make a difference?

A: (Delight Satter) Yes, exactly. We will have a clear, transparent process and an elected official can appoint an appropriate person for their area.

Q: (Jay Butler) What can we do as TAC members to assist with the recruiting?

A: (Delight Satter) Review the Dear Tribal Leader letter to see if it's effective. When we have a final version, Kim will send out an announcement; you can promote that. Our webpage will debut in a couple of weeks, so you can link to us and post on your own page.

C: (Kim Cantrell) Part of the communication will be a Dear Tribal letter and for those who we don't have email we will send hard copies.

Q: (Lisa Pivec) What if a chief delegates him/herself?

A: (Delight Satter) They would just change the language.

C: (Ramona Antone Nez) Navajo is not the only Tribe in our nation. We also have the Southern Paiute Tribe. We have the three bands of Navajos in the Albuquerque area, so it's not always as clear cut as the lines drawn by IHS.

C: (Kim Cantrell) As we move forward, we will review the letters we have on file and if they don't fit the nomination criteria then I'll talk to you about how we can get the right letter on file.

Q: (Ramona Antone Nez) There are references to ATSDR, why are they not at the table? Where are they?

A: (Judith Monroe) Dr. Frieden is the Director of CDC and ATSDR. I'm one of his Deputy Directors. We wanted Tribal Support to mirror HHS. We work closely with ATSDR. I represent Dr. Frieden and he is the Director of both.

Q: (Ramona Antone Nez) Are we advising them?

A: (Judith Monroe) You are directing Dr. Frieden. When ATSDR issues come up, Annabelle Allison will be here.

Q: (Ramona Antone Nez) So would it be appropriate for her to be here?

A: (Delight Satter) She doesn't serve on interdepartmental or high policy level issues. When you need a subject matter expert, she could be brought in.

Q: (Ramona Antone Nez) At the last meeting, we had one day of consultation; what should I look forward to at the next meeting? Will there be a time for consultation again?

A: (Delight Satter) We start working with Dr. Frieden on his schedule months in advance; but he just came back from China. In late December, we learned the only day he was available was in conflict with the HHS national area's consultation. Now we know to coordinate with HHS and vice versa. The only way to resolve the conflict was for us to cancel our consultation and convert to an extended meeting time. We are required to have one consultation a year, so we will have one in the summer.

C: (Chester Antone) We need to have our next consultation in Indian Country. Because USET [United South and Eastern Tribes, Inc.] has 35 Tribes, they won't be able to make this meeting because of the other consultation going on. We've been doing two consultations, when we are only required to do one.

C: (Kim Cantrell) We have it scheduled in our contract to have the meeting in Indian Country.

C: (Cathy Abramson) I made a recommendation to have our meeting in June in Hollywood Florida, so it can coincide with NIH's 4th Annual National Tribal Public Health Summit.

Q: (Chester Antone) Do we have a resolution on the discussion on the charter?

A: (Delight Satter) Administratively, it looks the same as it did in March. There have been no changes since June. Please submit changes if you have them. Operationally, I want you to understand that we need to begin recruitment for the open seats. The design of the 16 seats can be addressed, but those comments need to be submitted. It would be good to have a deadline.

Q: (Chester Antone) How long do we want to allow for edits?

C: (Jay Butler) I thought we were talking about distributing it.

C: (Chester Antone) That was in reference to the policy.

Q: (Alicia Reft) So we can't go forward with the charter until we have a policy?

A: (Delight Satter) We do have a policy. Even if it changes, the charter can be changed if necessary.

Q: (Alicia Reft) If you pass the charter now, can changes be made later?

A: (Delight Satter) We can make minor changes, but substantive changes have to go through the process again.

Q: (Delight Satter) Do you want 2 weeks to look at the charter and submit comments or do you think that has been done already?

A: (Chester Antone) I think we just need to do the recruitment, but if the membership wants to make changes then we should do so. In any case, we need an active charter.

C: (Delight Satter) It can be changed at will. Legally, you approved it at the Mohegan. Maybe we can set a process to review it now and when we have more members we can review it again at longer intervals. The Chairs may prefer Robert's Rules, so they can solicit a change.

C: (Alicia Reft) If Tribes are going to look at the policy, I think we should proceed with recruitment.

C: (Chester Antone) So, in the meantime we will try to fill seats and consider the charter okay.

C: (Delight Satter) Technically everything is fine; but I want to have the confidence of the membership that we should be recruiting and have no issues regarding the charter. We need to be able to tell our leadership that we are moving forward. There could be some counter voices to filling the seats, especially if people say the charter was never approved.

C: (Alicia Reft) I thought you said the charter was null and void.

C: (Delight Satter) Yes, but you could tell people wanted to participate. We can't be out of compliance. We will be sure to be in compliance.

Q: (Ramona Antone Nez) The policy that was signed in January, by Dr. Frieden, is finalized; but will we have Tribal input? Will it be sent out to Tribes?

A: (Judith Monroe) I talked with the Chief of Staff and we are committed to sending a Dear Tribal Leader letter out with the Tribal Consultation Policy. What I discussed was the language that goes out. If you open it too far, then it needs to go to the Federal Register.

Q: (Ramona Antone Nez) On the charter, is it in effect now?

A: (Delight Satter) Yes, but no, because of the actions on day three. Some people might say there is no charter. This is your document for the organization. You really haven't had any requests for changes.

Q: (Ramona Antone Nez) Are we trying to approve it today?

A: (Delight Satter) You could either move to approve it or reaffirm it to show confidence that it's what the body wants.

C: (Ramona Antone Nez) I'd like one more eyeball on it.

C: (Cathy Abramson) We are not having an official meeting now because we didn't approve the agenda.

C: (Delight Satter) You are following Robert's Rules.

C: (Ramona Antone Nez) I want to avoid the whole policy miscommunication.

C: (Alicia Reft) Approving the charter, with the understanding that further discussion can occur at the next meeting, gives me some comfort.

Q: (Ramona Antone Nez) I just want to avoid the miscommunication. If we approve it and new members come on and they want to give input, how open will we be towards that? We'll use some lessons learned from the policy.

A: (Alicia Reft) I think if it's documented that it's a living document, then any changes that come up can be dealt with.

C: (Ramona Antone Nez) There are some concern areas about the selection process and I would like to address them; so I'm not ready to move on the charter today.

C: (Chester Antone) It's my understanding that the document is currently in operation. We can still change it as we go, if we need to.

C: (Delight Satter) We didn't post it; it's not online yet. It is how we are recognizing you all. Can you think administratively of any cautions that we need to be aware of?

C: (Kimberly Cantrell) One of the biggest risks with not seating the vacancies is the funding could be moved to something that is more functional. From Gladys' presentation, we could move to change the committee to a FACA committee. If that

happens, you become provisional government employees and once the work is done the committee is dissolved. We want to keep this committee going.

C: (Delight Satter) The intention of this committee is for it to be permanent. We did lose some funding last year because we didn't have full composition.

C: (Jay Butler) Not all FACA committees just go away; that should be noted.

C: (Delight Satter) I'm not sure if it would be a conflict for some [of you] to be a Federal employee or not.

C: (Chester Antone) It would be nice to approve it, but it depends on the committee.

Approve Minutes

Ms. Cantrell indicated that the minutes from the last meeting could be discussed during the next conference call.

POIR—Performance Organizational Improvement Review

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

Ms. Monroe briefly addressed CDC's organizational improvement, under Dr. Frieden's leadership. She said there were independent evaluators assessing each office, including OSTLTS, who were prepared to interview the TAC members. Ms. Cantrell indicated that she would notify the evaluators to schedule another time to speak with TAC members, because of time restraints.

Wrap-up of Business Meeting

Chester Antone (Tohono O'odham Nation): Chair, TAC

Chairman Antone indicated that the remainder of the agenda items could be addressed in the future, so the day's meeting could be brought to a close.

Discussion Points

C: (Lisa Pivec) At the Oklahoma City Area Board Meeting, they wanted me to share a clear message here. They seem to be comfortable with the STAC and how it operates, but not this committee. I'm trying to compare the documents from both committees. I understand where we are with the Tribal Consultation Policy. I really hope it goes out as a document that is not final, but rather one that is open for comment. I want the perception of CDC to change.

C: (Alicia Reft) I think most people were upset about the process, not the content, surrounding the Tribal Consultation Policy.

C: (Chester Antone) In closing, I feel I have to defend the resolution we submitted. The agency did execute the policy and that's what we requested. We did feel as though time was allowed for comment.

C: (Cathy Abramson) I represent the Bemidji area and I'm on the NIHB. They want the seats on the TAC kept the same, so if that can't be done then we'd like to see it in writing.

C: (Delight Satter) The CDC Tribal Consultation Policy is a response to a White House directive of strengthening government relationships with Tribes. Dr. Frieden setup OSTLTS. The change in the core system and working through the details is what we are trying to do.

C: (Judith Monroe) I sit on the STAC for Dr. Frieden and we are trying to align ourselves with that committee. I do want to thank you for the comments and on the passion you've expressed about the importance of CDC in Indian Country. We have the best intentions. The process hasn't been smooth, so I want to again say "I'm sorry."

The first day of the TAC Meeting ended with Chairman Antone providing a closing blessing.

DAY 2

Opening/Welcome

Sandra Ortega, Councilwoman, Tohono O'odham Nation, started the second day of the TAC Meeting by giving the opening blessing.

CDC Director's Update

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

Dr. Monroe introduced Dr. Frieden, who greeted the group and reaffirmed the CDC's commitment to working with Tribal governments on a government-to-government basis. Regarding the CDC Tribal Consultation Policy, he told the TAC he would send a copy out with a request for feedback via a Dear Tribal Leader letter. In terms of the budget, Dr. Frieden said, "The 2013 budget is still under discussion; and the 2014 budget will soon to be released by the President." He also noted that CDC's budget authority has come down over the years, making it more reliant on the Prevention Fund of the Affordable Care Act (ACA). Notwithstanding, Dr. Frieden said funding for AI/ANs has remained relatively stable. He acknowledged the multiple visits by Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion, to

Indian Country, saying her center continues its efforts to improve the health of AI/AN populations. Next, Dr. Frieden shared the ten leading causes of death for AI/ANs. He noted that AI/ANs have the highest motor vehicle injury deaths; and as a result the CDC is working with Tribal nations on motor vehicle injury prevention programs. To address another problem, diabetes, he said diabetes prevention programs are using indigenous approaches, as well as looking at cardiovascular health more broadly. Other highlights of Dr. Frieden's presentation included the following:

- AI/AN adolescents are twice as likely to commit suicide as Whites. CDC is working with SAMHSA on enhanced evaluation at several sites.
- CDC has a workplan to improve relationships with States and Tribes and is trying to improve the capacity of its Indian programs.
- Rocky Mountain Spotted Fever (RMSF) is still on the radar. The RMSF Rodeo—a neighborhood pilot project that treated pets—showed great progress in reducing the number of infected pets. Based on that success, they are getting additional funding.
- CDC has sponsored two radio PSAs targeted towards AI/AN communities on influenza; and the CDC is partnering to increase adult vaccine coverage.
- Later this year the CDC will release tips from former smokers, featuring AI/ANs. Two ads are scheduled to air in spring 2013.

In closing, Dr. Frieden reminded the TAC that the CDC's goal is to improve health of all populations and to eliminate health disparities.

Discussion Points

C: (Ramona Antone Nez) Navajo Nation Livestock and Veterinary Services called upon CDC for assistance to prevent the spread of RMSF and your Epi response came to our nation, so thank you. With the serology and the report that resulted, we made a presentation to our Legislative Council and our President signed an emergency fund to address the underlying cause by doing outreach to the community to do more spay and neutering. Now, our animal control codes are being revitalized. So, thank you, on behalf of our nation. Your team has been very responsive.

C: (Jay Butler) From an Alaskan perspective, colorectal cancer support has been received by CDC via three grants. We also acknowledge the educational and support materials CDC has provided on TBI, as they have been very helpful. I want to bring three areas to your attention. In monitoring immunization rates, thanks for making sure clinical data gets into the registry; but many Tribal centers are not using RPMS, so can CDC play a role in working with vendors? We don't have the connectivity we used to have. Secondly, I want to bring up the connection between zoonotic diseases in wildlife and public health. There are concerns as to whether or not contaminants among animals are a problem. A challenge is finding out who is in charge. The connection between surveillance for human disease from wildlife is a great concern. The third thing is the Hepatitis C virus. We think 2000 people will need treatment, so any influence CDC has in influencing CMS/other third party payers will be helpful.

C: (Thomas Frieden) We will follow-up on that. I will ask our program to look at the registry, on colorectal cancer. What is your primary stream of modality?

C: (Jay Butler) We primarily use colonoscopy, sigmoidoscopy is sometimes an option. We hope in the next 5 years we can shift. We are monitoring through the Alaska Native Tumor Registry.

C: (Cathy Abramson) I continue to sing the praises of CDC's traditional foods program and encourage you to continue to support that program. We are getting healthier. I am a cancer survivor. I went through chemo and radiation and I used traditional medicine. I live in the Great Lakes region and we are concerned about our waters and the invasive creatures. Our white fish are getting smaller and we rely on the waters for many foods. The Great Lakes are the largest fresh water source in the world, so we need to protect them.

C: (Jackie Kaslow) From California, the Injury Prevention Grant is small, but it has had mighty success in our area. California has significant levels of motor vehicle related injuries. Our grant allowed us to work with a local Tribal Council to pass an ordinance to enforce California's safety belt law on the reservation. People with citations will receive education instead of fines. Please consider expanding the program. We also get the Garret Lee Smith Grant; thank you for the suicide prevention support in Indian Country. I hadn't heard that you are working with SAMHSA, so I'd like to hear more on that. In California we are experiencing a rise in prescription drug use. We heard SAMHSA created a taskforce and may be working with CDC. There is a significant gap in the capacity to address the problem on a local level. The problems stem from usage and access. We ask for help before the crisis becomes unmanageable.

C: (Thomas Frieden) We will follow-up on the Garret Lee Smith. The prescription drug problem is getting worse. There is a combination of patient and provider problems. There is a prescription drug monitoring program initiative, but it's not readily available. Getting standard guidelines for treatment will be important, as well as looking at other interventions. There is a behavioral health coordinating committee out of HHS.

C: (Michelle Hayward) My friends have lost four friends to prescription drugs. California doesn't work well with Tribes, so I ask you for direct funding. I'm concerned about this TAC. I would like you to suspend the Tribal Consultation Policy until all Tribes give input. We sit as a committee without a quorum. There are 12 areas and 4 at-large seats, but only 6 of us are represented.

C: (Thomas Frieden) I did say I'll be sending out a Tribal letter and we will encourage people to share comments.

C: (Michelle Hayward) I think it was signed without the proper process, so that's why I'm asking for this.

C: (Lisa Pivec) We have outlined disparities among Cherokees and identified the leading cause of death, which is lung cancer. I encourage CDC to look at public health infrastructure funding in Indian Country. I also urge CDC to look at Tribes as it looks at health systems and public health. I would echo Ms. Hayward's comments. Thanks for your reconsideration of the Tribal Consultation Policy. I think you need to send it out as a draft document for comment and not a signed policy; otherwise, it will be viewed as an afterthought.

C: (Chester Antone) Regarding RMSF in Arizona, on February 8th we have a meeting at a community college with CDC and IHS to see how we can stop its spread. I made a request to Herb Shultz to have CDC at the regional consultation in Phoenix. On the VFC program, we have questions on how that data is transferred to CDC. With the overall money to AI/ANs for grants and contracts, what percentage goes to AI/ANs (minus vaccines)? Working with the funding to States that have Tribal citizens, we tried to get language for States to confirm how they would use funds to serve AI/ANs. We don't know if the guidelines are still there. We thank you for the tracking system that lets Tribes know the status of issues raised. And thank you for providing additional staff [for OSTLTS]. We urged you to sign the Tribal Consultation Policy and we ask that you send it out as a signed document. Until you provide feedback on some of the testimony submitted over the years, you will continue to get the same requests and the same testimony.

C: (Thomas Frieden) In terms of direct funding, it's about 1 percent of our discretionary budget. We can get you the details. From what I understand, your desire is to have State, local, and territorial funding to go directly to Tribes (or for Tribes to be able to access them). I heard you on that. On the issue of the Tribal consultation, it sounds like we made a mistake. I hear the two perspectives; we can't make everyone happy. Whatever we send out we will take into consideration all the comments. I will consult with the lawyers, but the principle is an important one. We share the same goal of maximizing health and an important way of doing that is to have collaborative, open relationships.

Moving with Tradition Instant Recess, Fort Peck Assiniboine and Sioux Tribes

The group participated in an exercise activity that was created by Toni Yancey, MD, MPH, Professor of Health Services, Department of Health Services, UCLA School of Public Health and Co-Director, UCLA Kaiser Permanente Center for Health Equity.

Roundtable Discussion with CDC Senior Leadership

Chairman Antone invited all those seated around the table to provide a brief self-introduction, after which he opened the floor for issues to be discussed or for CDC leadership to request guidance/advice from the TAC.

Discussion Points

Q: (Corinne Graffunder) What are your thoughts about how to best prioritize opportunities for CDC, i.e., suggestions for understanding gaps that might exist for ensuring that in Indian Country we are promoting the availability of preventive services and health systems?

A: (Lisa Pivec) We, at Cherokee Nation, are moving towards accreditation. As we look at health care delivery and public health, look at Tribes for models that work. We've been able to make strides in the public health community because we recruited providers to deliver the message. I encouraged Dr. Frieden to continue funding public health infrastructure in Indian Country. Tribal health systems are a good place to look for innovative approaches.

Q: (Ramona Antone Nez) In terms of the ACA, how can we strengthen relationships with States in addressing behavioral health components of the ACA? How can we increase cancer screenings? Recognizing Tribal Epi Centers as a public health authority is a Federal mandate, but some States have questions. Regarding Insurance Exchanges, in Navajo we span over three States. Each State has a different Medicaid system. The Navajo Medicaid Feasibility Study will have a report provided to Kathleen Sebelius. We look to your office for clarifications.

C: (Jackie Kaslow) In California we have no direct service from IHS, so no hospitals or in-patient care. At the discretion of the state, things can be cut. California has gone to a demonstration project to expand Medicaid and is moving towards the managed care models. Tribal health programs have to figure out how to coordinate care with managed care systems. We have 58 counties in California. There are significant challenges. The ACA is creating more fragmentation in California. We could use assistance in increasing coordination of care, including law enforcement in public health initiatives. So, we could use technical assistance from CDC.

C: (Jay Butler) Looking at EHPs [Essential Health Providers], CDC can use its expertise to ensure items remain on the list. In Alaska, Medicaid expansion will greatly benefit Tribal health systems. I'm interested in more data on essential health benefits.

C: (Brock Lamont) We are responsible for the interface for immunization projects. I'd like feedback on what we do well and what we can do better.

C: (Michelle Hayward) Regarding the ACA, we had an issue with the ACA having a fourth definition of Indian. In California we take care of our non-Federally recognized Indians. I want to make sure this is in your ear. I think we got that achieved, the legislative fix, but I'm not sure.

C: (Brock Lamont) I can follow-up on that.

C: (Jay Butler) I want to thank you for the supplemental "317" budget. As a result, we are able to have a universal vaccine program. One of my concerns relates to registries.

We had challenges with vendor packages and our State registry. Perhaps CDC could work with vendors to facilitate this.

C: (Brock Lamont) I'll carry that message back. There is a group trying to provide guidance to vendors.

C: (Ramona Antone Nez) Navajo Nation wants to establish a laboratory. About the environment, we have many wastes related to uranium. We seek information on public health effects. The Tribal Environmental Think Tank is a good group. The Navajo Birth Cohort Study will soon end and we want to advocate for long-term funding. What are the other effects on Indian Country? I'm interested in immunization success rates, so I'd like to give you my contact information.

C: (Delight Satter) We can set up a conference call between Ramona and Brock.

C: (Chester Antone) We have some direct funding via grants from CDC, but when we talk about preventive services we need to look at how we deal with Tribal nations. When CDC consults with Arizona Tribes, I encourage attendance by a CDC [staff] member. Tribes are asking for consultation because we now need to focus on the Federally-facilitated Exchange (FFE). How do Tribes interact with this new Exchange? Some Tribes are trying to become accredited to be a health system. Data on immunizations need to be tracked.

C: (Ramona Antone Nez) Who has visited the Navajo Nation? [Many people raised their hand.] A year ago, in 2012, Vice President Jim met with Dr. Frieden and he said he would like to have seen more directors at the table. Thank you for being here; it demonstrates that the communication is there. On Navajo, we have three branches of government. The Division of health is led by Larry Curley. I found out, over my tenure, that we have many visitors come to see our health care system. My request is that you show courtesy to us by requesting entry into the Navajo Nation. Out of courtesy to us, please contact Mr. Curley; he is the appropriate person to reach out to, to say you are going to be doing business on our nation.

C: (Delight Satter) In Tab 14, you will see the HHS Regional Consultation Schedule. You may have staff in the field that can attend. Dr. Monroe and I will be at the majority of the sessions and we encourage TAC members to get CDC on the agenda. Navajo's consultation date will be forthcoming.

Q: (Michelle Hayward) On Region 9, has Herb Shultz stepped in?

A: (Chester Antone) Steven Weaver is the contact to get things going, he is Herb's aide.

C: (Annabelle Allison) On the Navajo Birth Cohort Study, we and five other agencies have been assessing uranium exposure on the Navajo. We got funding from FY 2010-12. The agencies are beginning discussions for the next 5 years. We would be interested in knowing what other areas of the study you will be considering. We really want to hear your issues related to exposures. Regarding impacts of uranium, we have

done other studies, so I can try to get information back. It's higher than the national average.

Q: (Chester Antone) On arsenic and water, is that the case with the Montana mine?

Q: (Annabelle Allison) Is this the Landusky mine?

A: (Chester Antone) Yes.

A: (Annabelle Allison) It's a gold mine. I'll have to go back and check the metal.

C: (Chester Antone) I believe the statement was that the water was safe for the environment.

C: (Annabelle Allison) We have reached out to the Tribe, but we are waiting for data so we can do analyses.

Q: (Chester Antone) I wanted to ask about climate change issues. I wanted an update on that. Also, I wanted to ask about the sessions on social determinates of health, are they still ongoing? I'd like feedback on these two issues.

A: (Hazel Dean) There were two symposiums on social determinants of health; and two special issues. We want to know how Tribes are collecting social determinants of work elements. We are working with Dr. Liburd to coordinate efforts across the agencies.

C: (Chester Antone) One request I made was to say, for each grant we apply for, which social determinate would be addressed.

C: (Hazel Dean) We documented in our surveillance system what social determinants were being addressed.

C: (Kathleen Ethier) We are trying to come up with better measures to the Healthy People process. I'm sure she would be happy to hear from you again on this.

C: (Chester Antone) We have our processes; so we need to sit down and look at your processes.

C: (Delight Satter) The TAC, for several sessions, had a rich discussion with Dr. Liburd and Donna McCree. They discussed the spiritual components of social determinants.

C: (Robin Ikeda) The National Center for the Environmental Health has the lead on issues related to climate, but I can find out the status of the document.

C: (Annabelle Allison) It's a reference to a workshop; I will get information on next steps in terms of what they intend to do with the document.

C: (Chester Antone) If the document can't be circulated, then the content has no meaning.

C: (Sandra Ortega) It's always good to come to Indian Country to see the issues we deal with first-hand. We had a community cleanup in my area and two kids, five and six years old, picked up a bag of cocaine. These are things we deal with. I ask for continued support of CDC's cleanup efforts. One of our clinics had a drive-through for flu vaccinations. That helped. So, we continue to look for innovative ways to reach people. RMSF was a challenge. I'd like to thank the CDC for its assistance.

C: (Jackie Kaslow) Thanks from the California area and on behalf of the TAC, because our partnership with CDC is critical. It's important that we believe we have a true partnership with you. This is the most number of directors and/or representatives that I've seen in a long while. If we continue to see it, I will have a greater report on the needs that we have. I'm hopeful that this representation will be maintained.

C: (Cathy Abramson) In response to the question about what you can do in terms of prevention, I'd say understand us, learn about us, and know that we believe our ways will restore our health.

C: (Jay Butler) Thanks to the centers that are here. I want to acknowledge the technical assistance we got on climate change and potential health effects. Kudos to ATSDR for its work on St. [unintelligible] Island. Oral health has a major impact on quality of life. We want to make sure CDC is aware of the importance of oral health in terms of quality of life. In Indian Country today, there is an article on Native approaches to oral health. Tribes have variable success with partnering with States, so thank you for the NPHII program. It creates a great partnership with States.

Q: (Chester Antone) If you train IHS to do lab testing, then you won't have to outsource it. How are we doing on that issue?

A: (Pam Diaz) I'll have to get back to you. I need to connect with the Laboratory [Sciences and] Services Office.

Q: (Chester Antone) To OPHPR [Office of Public Health Preparedness and Response], what is the major expertise [you provide] in helping Indian Country? What do you respond to most?

A: (Jeff Bryant) We look at how States spend public health preparedness dollars. We don't have a specific assessment on how money is being spent by Tribes.

Q: (Chester Antone) The money we get from the State is very low. I'm asking about how they direct that funding. Where do Tribes need the most assistance?

A: (Jeff Bryant) We don't have a lot of activities going on at that level. Let me ask the question and I'll get back to you.

C: (Chester Antone) You should also see if Tribes signed-off with the State before they received those funds.

C: (Jeff Bryant) That's a good point.

C: (Ramona Antone Nez) Regarding the public health emergency preparedness issue, we have brought up direct funding issues in our testimony. In our case, we cross State jurisdictions. Because the money is for States, there is no jurisdiction to cross State lines. The CDC Public Health Advisor wants to work us, but there is that issue of direct funding. I'm curious about your perception of that funding.

C: (Jeff Bryant) The legislation is strict. We understand the issue. There are numerous situations where the States really need to work together.

C: (Ramona Antone Nez) It also impacts response time. From the time a request is made to the National Stockpile, it goes to Phoenix and then to the Nation. When we make a request, the Stockpile should go directly to the Nation.

C: (Jeffery Bryant) Every State has a plan to reach its population within 48 hours. Systems are in place for that.

C: (Lisa Pivec) On behalf of the Oklahoma area, I want to thank you. I also want to echo the sentiment that investment in Indian Country often means an investment in the entire state. Funding can come through both Tribal and State initiatives.

C: (Judith Monroe) The tracking tool will be used to follow-up on items.

Introduction to Funding Opportunities at CDC

Ann O'Connor: Program Planning and Advancement Chief, Office of the Associate Director for Program, Centers for Disease Control and Prevention

Christine Kosmos, RN, BSN, MS: Director, Division of State and Local Readiness, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention

Ms. O'Connor spoke about work to create standards for strengthening cooperative agreements. As a result of listening to stakeholders, the following four recommendations were noted: more standardization in FOAs; engage stakeholders when building FOAs; have funding flexibilities, and [enhance] quality improvement. Ms. O'Connor said CDC's vision focuses on building stronger evidence-based [models], encouraging innovations, having more standard FOAs, and showing results of its investments. She said offices are working with programs on their FOAs as they are being written, especially on who is eligible, outcomes, and evaluation and measurement of programs. One benefit for Tribes is FOAs will be more concise (because of page limits). They will also be in the same format and require only one annual report, i.e., no more interim project reports and end of the year annual report. Additionally, grants will be made available to a wide audience as much as possible. Ms. O'Connor welcomed feedback on the new standards, asking if they make things easier. Finally, she said each program will be required to consider its target population and how the FOA

addresses issues of health disparities; and they are building in capacity to collect better data, as well as collect more data on how FOAs address disparate populations.

For her portion of the presentation, Ms. Kosmos talked about strengthening the Procurement Office. She gave a snapshot of the PGO (Procurement and Grants Office) and shared its mission—to support CDC programs and work of programs at state, local, Tribal, and international levels (by providing subject matter expertise on the grants and contracts side). Next, Ms. Kosmos provided high level tips in terms of making applications more competitive. She recommended: 1) Be responsive to the funding announcement; 2) Be prepared to receive funds from CDC; 3) Partner if needed; and 4) Be complete and timely. She said the PGO wants to work more proactively on the front end, as a business partner, and is reorganizing to develop more in-depth contract expertise in grants and contracts.

Discussion Points

C: (Cathy Abramson) I gave a list of concerns to Dr. Monroe at the STAC meeting. I wanted to share some of them. Tribes have concerns about these items: funds intended for Tribes and Tribal organizations are not reaching Tribal communities; award of planning grants with the promise of continuation funding for project implementation, through both competitive and non-competitive funding processes, with no follow-through; lack of understanding and cultural competence of grant reviewers; data and evaluation requirements do not reflect the unique issues that face Tribal communities when selecting, adapting, implementing, and evaluating programs; and a “one size fits all” thinking when creating programs and funding opportunities is not an effective process for potential Tribal grantees and the potential funder. I will get this printed and give it to you. There is a specific concern about funding that goes to universities; their indirect rate is 50 percent and little goes to Tribes. In terms of the grant reviewers, ANA [Administration for Native Americans] has a good model in that they have a lot of Native grant reviewers.

C: (Ramona Antone Nez) Our multi-jurisdictional area is an issue we continue to raise. We understand the importance of collaboration in the State Plan for Emergency Preparedness. We advocate for direct funding to the Tribes. We talked earlier about the possibility to have direct funding for emergency preparedness for the Navajo Nation. How can we approach this? If there is an emergency in New Mexico, we can't go and help. As I understand our sovereignty, it's hard to be dictated about who we can serve in terms of eligibility. Our eligibility includes our entire nation. We need a feasible and realistic solution to this issue; then we can stop talking about this in our Tribal testimonies. Any technical assistance you can provide to help us get through the barriers would be helpful.

C: (Christine Kosmos) In the preparedness world, States depend (and locals depend) on working with other adjoining States. It's common practice for one impacted community to hold out a hand to another impacted community. If there is something preventing you from doing this, then this is something we need to work on. Greg, we

will need to bring that back; we can talk to you more. The whole idea is “neighbors helping neighbors.” We need to help you get that done if you have barriers.

C: (Chester Antone) Regarding community-to-community and State-to-State issues, I will use a different example about how we need to think about this. We need to know how States that have Tribes are implementing programs. We have partnered with Arizona and we have an agreement to cross the Mexico border for emergency preparedness. States get CDC funds and should therefore be cooperative. We often hear about drug abuse, but resources aren't there to address it. In my Tribe, if we don't have funding to curtail it, it will reach Phoenix or Tucson. We have 80 miles of international border. In order to block it we need funding to the Tribe. So these are not isolated incidents, they affect larger areas eventually. If States won't cooperate, CDC can do a separate allocation in the form of a Tribal set-aside. I know CDC has a hesitation regarding this, but we are a government, not a minority group.

Q: (Ramona Antone Nez) Thanks for the standardization efforts. In my Division of Health we have no grant writer, so programs fend for themselves to get an application submitted. Once we get a grant, it goes through our fiscal component and then to our legislative branch to accept the money. It's a long process. Do you have upcoming webinars, teleconferences, or trainings about best approaches to be effective respondents to the FOAs?

A: (Ann O'Connor) We just launched this new standardized template. There will be roughly 50 new FOAs that will be in the standard template. All along, we thought about how to get the word out to the awardee community. We have not forgotten this part. We will reach out to partners to accomplish this. We just have to keep it available to all applicants. There will be more to come on this.

C: (Chester Antone) It seems like you are beginning to listen to Tribes. I commend you for taking that route. Thank you.

Discussion of Collaborative Efforts with Dr. C June Strickland, PhD, RN (University of Washington): Grant Writing Tutorial

Molly Sauer: Public Health Advisor, Public Health Associate Program Graduate

Ms. Sauer shared information on a series of grant writing trainings developed by Dr. June Strickland, Associate Professor, University of Washington, specifically for Tribal applicants. She indicated that the trainings are now available online, saying she would email the link to the group. After showing one of the trainings, Ms. Sauer discussed a new activity Dr. Strickland is working on with Kathy Kensie (sp). She said two new videos will show a team working through an entire FOA. Ms. Sauer relayed Dr. Strickland's request for feedback on the training sessions, as well as recommendations on how to best promote them.

C: (Michelle Hayward) I would suggest reaching out to the Tribal Health Clinics, Tribes, the National Indian Health Board, and others to get the information out there.

C: (Chester Antone) You have a Tribal listserv, so you can send them the link and get feedback that way.

C: (Delight Satter) Dr. Strickland is a longstanding colleague of mine and she is an NIH [National Institutes of Health] top level researcher. She used to do summer trainings on grant writing and the National Institute on Nursing Research funded her to convert them to web trainings.

Closing Blessing

The meeting closed with Sandra Ortega giving the closing blessing.

DAY 3

Introduction/Welcome

Chester Antone (Tohono O'odham Nation): Chair, TAC

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

Delight Satter, MPH (Confederated Tribes of Grand Ronde): Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

The third day of the TAC Meeting began with Chairman Antone inviting Ramona Antone Nez, Navajo Area Authorized Representative and Director, Navajo Epidemiology Center, to give the opening blessing. Following the invocation, Ms. Satter welcomed the group. She introduced April Taylor, Public Health Analyst, Tribal Support Unit, OSTLTS, Office of the Director, CDC, to review the materials in the meeting binders. In preparation of recruitment activities to increase TAC membership, Ms. Satter asked the existing committee members to review the draft flyer on previous and current TAC membership and provide feedback to her within 2 weeks. Referencing the development of Instant Recess by Toni Yancey, MD, MPH, Professor of Health Services, Department of Health Services, UCLA School of Public Health and Co-Director, UCLA Kaiser Permanente Center for Health Equity, Ms. Satter noted how the 10-minute activity breaks assisted Fort Peck Indian Reservation heal from a suicide epidemic. To that end, she encouraged the group to support health promotion activities in their communities.

Dr. Monroe also welcomed the group to the consultation. She acknowledged the productivity that occurred over the course of the TAC meeting; and she reflected on events that reminded her that each person has a limited time to make a contribution in his/her life. She thanked the Tribal leaders for their candid discussions; and she reiterated the importance of the TAC to the CDC. With a shared goal of better health for Tribal nations, Ms. Monroe said she was reminded of the important issues they need to manage, e.g., impact of the ACA on Tribes. She also noted that CDC has as a goal the intersection of health care and public health, saying there is an opportunity with Tribal governments to see models of success. After reflecting on discussions from the previous 2 days that most impacted her, Ms. Monroe reminded the Tribal leaders that on the other side of working through difficulties is often a more productive, better place.

Tribal Support Update

Delight Satter, MPH (Confederated Tribes of Grand Ronde): Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

Ms. Satter provided the attendees with an update on the Tribal Support entity at CDC. She reported that last year's focus was on infrastructure building and communication. Among the accomplishments she cited included an expansion in the number staff; initiation of quarterly Project Officers Meetings for those that have official duties in working with Tribes; development of a tracking tool to follow-up on issues raised by Tribal leaders; and work on various policy areas. Regarding the tracking tool, Ms. Satter suggested that a demonstration be provided on a future teleconference to facilitate the TAC in providing recommendations on how to prioritize the items. She also suggested that the TAC hear a report from CDC's Project Officers at its next meeting. She directed the group to the binder of meeting materials for the CDC/ATSDR 2012 Tribal Consultation Report Part IV—an annual report to Congress that highlights all of the CDC's activities in Indian Country. Other notable items/comments from Ms. Satter's presentation included the following:

- CDC will have representation at as many of the HHS Regional Consultations as it can.
- Tribes are encouraged to comment on Dr. June Strickland's online grant writing tutorial sessions and provide feedback on how she can best disseminate her work on grant writing.
- Active work is underway on the 2013 Funding Opportunity Announcement (for a June 2013 release), with a focus on direct funding to Tribes for capacity building in public health when possible.
- Fellowship opportunities are available at CDC and other sister agencies; and Tribes are encouraged to participate in the PHAP.

Update on the Compendium of Stories

Holly Hunt, MA: Chief, School Health Branch, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Doris Cook, PhD, MPH (Akwesasne Mohawk): Consultant

Ms. Hunt and Dr. Cook served as co-presenters to share public health success stories and update the Tribal Leaders on the compendium project. Ms. Hunt first thanked the communities that shared their stories. She explained that the compendium project came about as a result of the TAC's request to Dr. Bauer to gather more lessons learned from Tribal communities. Ms. Hunt directed the group to the draft stories provided in the meeting binder, asking for feedback on them.

Dr. Cook explained that the stories are about Tribal initiatives that engage partners other than CDC; and they are focused on public health programs. Having worked on three of the stories herself, Dr. Cook said communities identify partners, e.g., foundations and other communities, as a critical component to the success of their programs. She said they cite partnering with the Federal government as the lowest of their success factors. As part of her presentation, Dr. Cook highlighted the work being done at Jemez Pueblo in New Mexico to reduce the problems of obesity and diabetes via MoGro—a project to bring a mobile grocery store to five pueblos in New Mexico. Since the project started last June, she said the communities have benefited from access to fresh and nutritious foods; and greater demand has led to increased hours of operation. Despite having received Communities Putting Prevention to Work grant funding in 2010, to plan the comprehensive program, Dr. Cook said the project demonstrates that even without CDC funding communities can do great things.

Discussion Points

Q: (Ramona Antone Nez) As part of the evaluation component, do they collect BMI [body mass index], glucose levels, blood pressure, and/or other markers?

A: (Doris Cook) I can't answer that, but I know they are collaborating with FITTness Challenge and there is a fitness component. There is also a bike club for children that maintains fitness data. They are keeping records on nutrition classes and participation rates.

C: (Lisa Pivec) We worked with the pueblo as a mentor and it was powerful lesson in chronic disease. We learned that having the Cherokee Nation mentoring a pueblo is not a great model. It was difficult to have phone conversations for a long time. Folks from chronic said they learned a lot about mentoring. They have done a wonderful job with this project.

C: (Ramona Antone Nez) My suggestion is that in addition to the participation rates, that another form of information gathering be implemented. A lesson learned is Navajo received funding from the Special Diabetes program and we collected participation

rates, but we are challenged in showing significant impacts made on the decrease in Type 2 diabetes and BMI. We are now improving our data intake so we can collect more meaningful data. There is behavior and cognitive change over time that can result from eating healthier foods.

C: (Doris Cook) I will take that back to the community. I would not be surprised if they are in the process of collecting such data. The process is very new, but I think it's premature for them to have evaluation data at this time.

C: (Chester Antone) I like the idea of partnering with the co-op and more importantly that Jemez is under HHS. We've tried to highlight more traditional foods, but stores want to make a profit. The idea of putting it under a health department carries a lot of weight in terms of people having access to food. The mobile unit is very convenient. If you try to convince a store to sell these items, it could take a while. We have a large land base. In my district we travel 55 miles for a grocery store. If you cut that distance in half and provide nutritious food then you get around the profit making scheme of the stores.

Q: (Jackie Kaslow) In California we also have highly remote areas. I would like to know access rates and if people with low income have some type of support, e.g., food stamps, have access to the fresh foods. Was the pricing maintained at a certain level? The concept will translate well, but a deep analysis on access and what the challenges are would be helpful. It would be nice to know how other communities could model this program.

C: (Lisa Pivec) The evaluation was set up on policy change and that was done through CCPW. They may not have been guided to collect that data, but I won't be surprised to know that they've added some things.

C: (Doris Cook) I wouldn't be surprised if other data is being collected. Because it's a co-op, the prices would certainly be more reasonable. The place they located the mobile unit is a central location next to a senior center. It benefited those seniors that choose not to drive.

Q: (Delight Satter) With the first round of stories, we'd like feedback from the TAC. We could post the stories in *Have You Heard?* and on various web pages. Should they be printed and distributed? What would you recommend?

Q: (Jay Butler) The issue is who is the intended audience and what outcome(s) do you want to achieve from the stories?

C: (Holly Hunt) The TAC asked Dr. Bauer to share the lessons learned, so the intended audience is Tribal communities, e.g., practitioners.

A: (Jay Butler) Then I think *Have You Heard?* is an excellent tool.

C: (Holly Hunt) The end goal is to have a compendium that speaks to what works well across communities.

A: (Chester Antone) Often we get concerned that the stuff that comes out goes to Tribal leaders and doesn't reach health departments. You should find the health department websites and send information to them. Maybe a prologue that explains what the document is and why it's being sent would be helpful.

Q: (Cathy Abramson) Are you telling the stories through video?

A: (Doris Cook) The stories are in narrative form, but it is possible to do them digitally.

C: (Cathy Abramson) NIH has a web page and regional health boards have web pages. Our Tribe also has a website. Tribal leaders and health directors do go to these. As a Tribal leader, I'd like to get the information and do a presentation to our Tribal leaders.

C: (Delight Satter) We have a few ideas that OSTLTS can support. We will move forward with making the stories available on the web, with a nice introduction that attracts people. We will work with our partners to have them link to the information. Now we have been asked to create a generic CDC/TAC PowerPoint and one TAC presentation to use to introduce this to communities as examples of what can be done.

Q: (Jackie Kaslow) Is it possible that OSTLTS has its own repository of resources on its webpage?

A: (Delight Satter) It doesn't exist. That is part of our goal, to centralize communications. In a couple of weeks we will have a newly designed webpage and it will have a feature for other centers to share their resources.

C: (Judith Monroe) The STLT gateway is in its next phase for the very reason you mention, because people had difficulty navigating the resources. We will refine it and take lessons learned.

Discussion on CDC Laboratory Specimens

David Holmes, PhD: Director, Division of Laboratory Policy and Practices, Centers for Disease Control and Prevention

Dr. Holmes addressed the issue of specimen management with the Tribal leaders in attendance. First, Dr. Holmes shared the mission of the Laboratory Science, Policy and Practice Program Office (LSPPO)—to provide leadership, advocacy and cross-cutting services to continuously strengthen the quality of laboratory science, policy and practice at CDC, in the U.S., and globally. After showing the organizational structure of the division, Dr. Holmes addressed the proposed approach for developing CDC's policy for managing AI/AN specimens. The approach, a joint effort with OSTLTS, includes identifying and engaging stakeholders; and eliciting participation from representatives from indigenous communities, the CDC TAC, CDC scientists, and others. He noted that work on an overall CDC policy for specimen inventory management sparked the need

for the AI/AN-specific policy. Dr. Holmes reviewed existing models for collecting specimens, discussing various policy considerations, e.g., informed consent, privacy and confidentiality, and protocols for use. In closing, Dr. Holmes asked:

- What other concerns need to be taken into account?
- What are the expectations of Native communities?
- With the help of the TAC and other stakeholders, how can CDC best address the issues?

Q: (Jay Butler) Have you maintained personal identifiers for the specimens?

A: (David Holmes) We don't have that at this time.

Q: (Jay Butler) How specific might the Tribal identification be? Would it just be ethnicity?

A: (David Holmes) I know they come from Native Tribes, but there is no personal identifying information. The plan is to store the information appropriately and then as a policy is developed we can go from there. The investigators may have more information than we have at the CASPIR [CDC and ATSDR Specimen Packaging, Inventory and Repository facility].

Q: (Delight Satter) Some of the specimens are from 50 years ago; that level of detail may not have been considered. When we identify specimens and the Tribal identity is uncovered, then there will be an approach established. If we know the specimen is Native, but part of an infectious disease study, what do we do?

A: (David Holmes) It may be difficult to get the information down to a person level for much older specimens, so we will look for guidance on how to handle this.

Q: (Chester Antone) I took this issue to our Cultural Preservation Committee and they said it's important to know if the specimen is a person that is alive or not. The NAGPRA [Native American Graves Protection and Repatriation Act] applies for Native remains. If you can find out which area they come from then claims of affinity can be done by any Tribes in the area. It becomes important to know if they are alive or have passed on. Does the CDC IRB [Institutional Review Board] have a clause for destruction of specimens?

A: (David Holmes) I don't know. We will get back to you on that.

Q: (Chester Antone) Do you have informed consent?

A: (David Holmes) I'm not sure about the older collections. Once we identify the Native specimens, we will share all the information we have, so you can help us determine how to proceed.

C: (Ramona Antone Nez) This is a sensitive topic. We have a history of being studied without informed consent. You are embarking on a large project and will need input from indigenous representatives; I encourage that. Many nations have Tribal codes around research, especially involving specimens. We have a Navajo Human Research Review Board. In the code it says any specimen collected is the property of the Nation

and must be returned to the Nation at the conclusion of the study. I urge you to take that consideration seriously in your policy development. Navajo has a moratorium on genetic studies. The [timing on the] lift of that is to be determined. There is no expiration on it. To come into our nations, you have to respect the government-to-government relationship; that is an expectation. You should inform the leaders and department leaders that you are coming and tell them the expected outcomes of the working relationship. Entry into the [Navajo] Nation may mean going through the Tribe's IRB.

C: (Jackie Kaslow) I think it's critical that I echo Ramona's comments. This is probably the most sensitive topic you will encounter in Indian Country. I've heard testimony from the Havasupai. This is a highly contentious area. One word you used provokes anxiety and that is "ownership." That word will be the basis for disgruntled communications. Seek Tribal input when developing your policy. In California, we have 109 Federally-recognized Tribes and close to 50 unrecognized Tribes. A specimen that predates legal authority can lead to a lot of contention. A great need of sensitivity needs to be taken. Seek significant Tribal leadership input. I don't know if you will have a draft policy or listening sessions, but we should be able to prepare our communities well in advance.

C: (Delight Satter) We know this is sensitive and we request that you help guide us through this process. We have asked the STAC for its input as well. As you know, once we fill our seats, we can have greater input. This is not on the "fast track." We are taking our time to hear from everyone. We will follow models like the Canadian model to ensure every Tribe is part of the development of the policy. I'm thankful to LSPPPO for taking this very seriously.

Q: (Sandra Ortega) As Natives, it hurts to find out that part of us is stored somewhere and not knowing how long that will be the case. It hurts to know that our spirits are out there, roaming. For those that had communicable diseases, what will you do?

A: (David Holmes) I'm not aware of any Native samples that were part of a communicable disease study, but we would seek your guidance on how to handle that on a case-by-case basis. We wouldn't want to give you something that is hazardous.

C: (Sandra Ortega) We request that specimens be treated with the upmost respect. A medicine man or woman, a spiritual leader, plays a role in how we handle the remains of our people; so we ask for respect because they are the remains of our ancestors.

C: (Jay Butler) Regarding the issue of ownership, about 10 years ago we addressed this issue in Alaska. The conclusion was that the specimen belonged to the individual study participant, but different Tribes may have different desires on how that issue is addressed. Recognize that the specimens are from human beings and therefore you have a responsibility concerning them. As you said, some of the specimens are quite old and some participants may not even be aware that they were part of a study.

C: (David Holmes) I want to assure you that we want your input and we want to do this right. We will be reaching out to you and diligently identifying all the information we can for specimens we have in CASPIR.

Moving with Tradition Instant Recess®, Fort Peck Assiniboine and Sioux Tribes

Meeting attendees viewed a video of and participated voluntarily in an Instant Recess exercise break.

Traumatic Brain Injury

Victor Coronado, MD: Division of Injury Response, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Dr. Coronado discussed the issue of traumatic brain injury (TBI). He defined TBI as “a brain injury caused by a bump, blow, or jolt to the head, or a penetrating head injury that disrupts the normal function of the brain.” Among the symptoms of TBI include difficulty with concentration and memory, headache, ringing in ears, and sensitivity to light and noise. Dr. Coronado also provided data on the burden of TBI in the U.S., saying there are approximately 3.5 million cases of TBI a year. He went on to share statistics on rates by sex, age group, race, and other variables; and he said 80 percent of TBI cases are mild, with loss of consciousness not lasting for more than 30 minutes. Other cases have moderate to severe outcomes, with some individuals being disabled for the rest of their lives. He explained that the CDC is concerned because TBI can lead to cognitive impairment; psychological and emotional changes; it affects community and society; and more. Dr. Coronado shared strategies for preventing TBI, e.g., use of seat belts, wearing a bicycle helmet. Finally, he talked about the “Heads Up” initiative for physicians, coaches, athletes, and others; and he noted that almost every State has passed legislation to prevent injury among youth playing sports. Dr. Coronado closed by stating that the CDC is among over 60 other organizations addressing TBI.

Q: (Jay Butler) Looking at the statistics, “other” is a huge category; and where do off-road vehicles fit? What about combat?

A: (Victor Coronado) We don’t have data for things that occur outside of the country. There are statistics for the military. The “other” category may be multiple injuries and/or multiple traumas, or the physician doesn’t document the cause.

Q: (Ramona Antone Nez) Suicide rates are high among AI/ANs, does this capture part of that?

A: (Victor Coronado) You will find that information in the [unintelligible].

Suicide Prevention

Alex E. Crosby, MD, MPH, CDR: U.S. Public Health Service, Medical Epidemiologist, Acting Branch Chief, Surveillance Branch, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Dr. Crosby talked about the CDC's efforts in suicide prevention specifically related to a public health approach. First, he said, the problem is assessed; then identifying causes determined; programs and policies developed and evaluated; and finally implementation and dissemination of programs to communities, States, etc. Dr. Crosby told the Tribal leaders that suicide is the 8th leading cause of death for AI/ANs, and doesn't make the "top 8" for any other ethnic group. Furthermore, he said suicide ranks higher than 8th for specific AI/AN age groups. Next, Dr. Crosby discussed activities related to looking at suicide, e.g., surveillance data. Regarding the NVDRS [National Violent Death Reporting System], he said it began in 2002 (currently 17 States are funded). Dr. Crosby explained that the NVDRS links data from the police, coroner, medical examiner, crime lab, and death certificates. As an example of how the system influences programming, he said Oregon had a Youth Suicide Prevention program, but developed a lifespan approach to suicide prevention after NVDRS showed the State's highest [suicide] rates were among those over 65. As part of his presentation, Dr. Crosby stated that the CDC is looking at the prevalence of intimate partner violence, sexual violence, and stalking among AI/ANs as part of its National Intimate Partner and Sexual Violence Survey. Finally, he talked about collaborations with Tribal Epidemiology Centers to inform and provide technical assistance to Tribal governments and communities. In conclusion, Mr. Crosby said health inequities exist for many forms of violence and public health has a valuable role in addressing these problems.

C: (Jackie Kaslow) Death records don't always classify race data. In California we had a big problem with race data on death certificates.

C: (Alex Crosby) You are correct; I've even heard some studies say up to 25 percent of people born Native die as something else.

C: (Jackie Kaslow) In California we get the SAMHSA [Substance Abuse and Mental Health Services Administration] Garret Lee Smith grant. One achievement we want to have is to have our Epi Center be a single reporting agency for suicide attempts, because we distrust the state-wide reporting system. I ask that you offer technical assistance with setting up surveillance systems.

C: (Alex Crosby) I know California has been on some of our calls and we have tried to provide assistance when asked. In regards to the Garrett Lee Smith Memorial Act, we worked with SAMHSA to look at more enhanced evaluations. We published some lessons learned from this; one product was a cultural appropriateness survey for youth. We also asked about protective factors.

C: (Jackie Kaslow) I'd love to have a side conversation before the end of the day; we have not been included in that enhanced evaluation. We could benefit from technical assistance.

C: (Alex Crosby) Sure.

Q: (Jay Butler) I think you are working with the Alaska Native Epi Center. We have an interest in Alaska in early childhood experiences. Is there any evidence about screening for adverse child experiences?

A: (Alex Crosby) The initial ACES [Adverse Childhood Experience Study] [unintelligible] higher scores had more adverse health outcomes including suicide behavior. We are doing more replication of that survey instrument in other populations. We are also looking at child abuse and neglect and trained community workers' work.

Q: (Cathy Abramson) How many head injuries/traumas are because of birth?

A: (Victor Coronado) Our data exclude birth; we look at mechanical events only.

Q: (Ramona Antone Nez) Is stroke considered a TBI?

A: (Victor Coronado) It should be, but it's not. It needs to be a mechanical event.

Q: (Jackie Kaslow) At a stakeholders meeting in California, one concern raised was about evaluation and the lack of standardization for assessing suicide issues in California communities. Can I speak to your staff on that later, please?

A: (Alex Crosby) Yes.

Q: (Jackie Kaslow) Victor, can data be disaggregated to be on a State level?

A: (Victor Coronado) I can't promise that because the population of Natives is tiny, so using State level [data] will be difficult.

C: (Delight Satter) I got a call about how one goes about activating the Commissioned Corps when an event happens. I wanted Larry Alonso to respond to this.

C: (Larry Alonso) From the Tribal community, a request can be made from the political structure of the Tribe to IHS or HHS, who will contact the Assistant Secretary of Health and [unintelligible] to deploy the Commissioned Corps.

C: (LeMyra DeBruyn) More often than not there are tiers in the Corps; mental health tiers are level two and they have been asked to help in Native communities when there is death. A letter is typically written by the Tribal government. Services often include mental health services and can include Epi assistance. We will try to get information in writing to share with Delight to put in your minutes on the exact process.

C: (Larry Alonso) The Commissioned Corps stages training sessions in communities to get the deployment familiar with local customs. The Corps becomes familiar with the community it serves. If you want to host a training (and dollars are available), that's another way to establish a path.

C: (LeMyra DeBruyn) Those trainings can be tailored to meet a community's need.

Q: (Jackie Kaslow) Before [the shooting in] Sandy Hook occurred, we had a mass shooting in California. CRIHB is not IHS and not a Tribal government, however we operate "638" contracts. So, IHS contacted us to deploy a response. So, when you say it has to be government-to-government relationship, if we act on behalf of Tribal governments to respond to a public health crisis, would we be barred from accessing your services?

A: (LeMyra DeBruyn) Absolutely not. We are available to anyone when there is a crisis.

C: (Jackie Kaslow) IHS was not directly responsible for that Tribe because the Tribe was a "638" Tribe. I'm disheartened to know we could have accessed CDC resources; but I'm glad to hear about it now. These two issues are important to California, so I appreciate the extra time spent on this conversation.

C: (Victor Coronado) We are doing a paper on TBI suicides.

C: (Jay Butler) The toolbox of resources that CDC has is rich. The Epi aide has historically involved the State health departments, but it sounds like that is changing.

C: (Alex Crosby) A few years ago we responded to Rosebud. They had a suicide cluster and Epi aides went out to identify risk factors. The invitation came from the Tribal Council.

C: (Chester Antone) There are other deployments that have been done, so these things do exist. Hopefully that information is getting out to everyone.

CDC's National Intimate Partner Violence Surveillance System and Intimate Partner Violence

Kirsten Rambo: Senior Service Fellow, Intimate Partner Violence and Sexual Violence Team, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Ms. Rambo discussed the DELTA Focus initiative—a program that focuses on primary prevention of intimate partner violence (a.k.a domestic violence). The 5-year cooperative agreement (2013-2018) will fund 10 grantees (all State Domestic Violence Coalitions) which subcontract with 1 to 2 Coordinated Community Response (CCR) teams, i.e., local multi-sectoral coalitions. Ms. Rambo said the initiative, from the beginning, has been focused on creating a culture where violence is not acceptable and it doesn't happen. She cited the goals of DELTA Focus, stating that the initiative looks at micro level structures that impact the likelihood of violence. There will be a focus on capacity building, as well as engagement with national partners, and programmatic evaluation. The anticipated outcomes include:

- Changes in policies, programs, structures and other social determinants of health at State and local levels that impact risk and protective factors for intimate partner violence.
- Increases in protective factors and reductions in risk factors for intimate partner violence.
- Program evaluation data on intimate partner violence prevention strategies that can facilitate the creation of practice-based evidence for intimate partner violence prevention at the societal and community levels of the SEM.

In closing, Ms. Rambo shared an example from DELTA Focus from Alaska, which had a large focus on Alaska Native communities.

Q: (Ramona Antone Nez) Dr. Coronado said one out of five Native households have no one working in the house. As members of the community, how do we address economic development so we can get more work, to get income, to get food, to have a safe environment so our community members can go outside and be active? Regarding domestic violence evaluation, how are you evaluating the effectiveness of the program?

A: (Kirsten Rambo) You are right about economic development. About evaluation of DELTA, it's not an effectiveness trial; but, we are evaluating at State and local levels. The first year is a planning year, its strategy, so most evaluation is a program evaluation. So, what are risk and protective factors the program wants to get at?

C: (Alex Crosby) One thing that has been talked about is "health in all policies." I think people are trying to do some integration that will help communities grow and nurture and be healthier.

C: (Ramona Antone Nez) I didn't mean to say money makes everyone happy; there are communities with money that still have disparities. Alcohol is also a contributing factor for suicide and TBI.

C: (Victor Coronado) If you look at the rates of people on reservations, 56 percent of car crashes are linked to alcohol. That's much higher than the national average. Alcohol consumption and domestic violence occur when people have lower economic status; so we have to consider how to empower people.

C: (Jay Butler) I appreciate the discussion on social determinants of disease. The problems people medicate are often socio-economic. The problems are interrelated. I'd request that CDC be careful about stigmatization when having discussions on racial/ethnic stratifications, as the media will run with it to connect data to perpetrators.

C: (Alex Crosby) We have seen in some research, especially with regard to sexual violence of AI/ANs, perpetrators tend not to be AI/AN men. Your point is well taken.

C: (Kirsten Rambo) Thank you for that comment. It's a challenge to talk about some of these issues without stigmatizing a particular race; so it is something we continue to think about.

C: (Jackie Kaslow) I'm happy we had a discussion about social determinants of health and I'd like to focus on the role of Tribal law enforcement in a public health capacity to address issues around suicide and intimate partner violence. The information presented has been very impactful, so thank you.

C: (Chester Antone) When we talk about macro versus micro level, macro means going beyond the sense of community. The progress that we make is a different matter. One of the ways CDC can assist is to understand the government-to-government relationship versus race. We run into that issue when we talk about doing Tribal set-asides. They say they are not favoring any minority over another; but we are talking about governments.

Diabetes—A Public Service Announcement Debut: Our Cultures Are Our Source of Health

Larry Alonso, FNP-BC, CAPT: U.S. Public Health Service, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Mr. Alonso addressed the issue of diabetes. He began the presentation by thanking the TAC for its guidance on the Traditional Foods projects. He also acknowledged the support of Tribal communities that have been engaged in the projects, as well as direction received from Tribal elders. Mr. Alonso discussed a series of PSAs that will be launched nationally, showing them for the first time to the TAC. The PSAs reinforced the notion that "culture is a source of health and a way to talk about health" and they provided a platform for discussion health education. He thanked the Cherokee Nation for its hospitality during the creation of the PSAs. Following Mr. Alonso's remarks, Jim Cosro (sp) talked about distribution of the PSAs.

C: (Cathy Abramson) For too long we have been invisible, so you are helping us show the world we are still here and we are trying to get ourselves healthy.

C: (Chester Antone) We've had other PSAs done by Mr. Studi; he seems to be taking a bold step forward in representing the Natives. I think at some point there needs to be an acknowledgement of that by CDC or HHS. I also want to thank the Cherokee Nation for its part in this. Larry, you and Dawn [Satterfield] always attend these meetings and you are becoming a permanent fixture at the TAC. That's good, because we know the issue of diabetes is being addressed. I hope we continue to find ways to get the information to the public. It takes a lot of Tribal work to get CDC to do this work. As long as we continue, I believe we will be able to control our diabetes rates.

C: (Lisa Pivec) We've been involved with Larry and Dawn and his staff for over 5 years and they are the some of the most respectful, open minded, and caring people that we have worked with. I've always been impressed with their commitment to Native issues. In the PSAs, everybody (with exception of one person) is a Cherokee citizen or member and a traditional foods person. A lot of the folks in the PSA were impacted beyond filming the PSA. It has been a good example of a model to follow to do future PSAs in other communities.

C: (Sandra Ortega) A lot of efforts are there to curb the diabetes numbers. The number we should really focus on is being number one in health. The PSAs were moving and they give hope. A lot of people suffer from diabetes. I encourage everyone to be encouraging to youth and remind them they are the most valuable resource we have for our future.

C: (Jackie Kaslow) CRIHB is not an awardee of the diabetes or nutrition programs currently, but we have a great deal of respect for the support that Larry and his team have always shown us. Their passion shows through in the PSAs. When the video started rolling, I was thinking "that's not my community;" but, I appreciate that it is forward thinking and you are bringing our issues to the mainstream arena. It's a job well done. Efforts like this are trailblazing. One way this type of work has helped California communities was with the HIN1 PSAs. The California Department of Public Health had been holding a grant award from us and through the CDC's efforts and the PSA, California released the funds and we were able to create PSAs to reflect our community. So, even when it's not "my community" on the screen, it helps my community.

C: (Ramona Antone Nez) It's a pleasure to meet you. With the traditional foods we eat, the seeds are what we hold of great value. They lead to food sovereignty. There is the issue of cross-pollination. Some companies claim they have the right to take our seeds; that part of the food intake needs to be part of the education.

Circles of Care and Systems of Care Programs (SAMHSA)

Andy Hunt, MSW, LICSW, CAPT, U.S. Public Health Service: Public Health Advisor, Child Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Mr. Hunt joined the meeting via telephone. He talked about the systems of care approach that guides two SAMSHA grant programs. First, Mr. Hunt shared a definition for a system of care (from Beth Stroul): A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. He described the core values of the systems of care approach: family driven and youth guided; community based; and culturally and

linguistically competent. Next, Mr. Hunt discussed the guiding principles around systems of care, stating that everyone has a role to play in helping the individual be well. The model, he said, is a paradigm shift in terms of how systems function to provide support. He added, "There is no prescription for using a system of care concept; it's more of a guide on how to work together." Mr. Hunt emphasized the importance of youth being empowered to give feedback/input; and he noted that AI/AN grantees have developed a system of care approach that is built on their Native culture. SAMHSA's two programs to help AI/ANs are the Child Mental Health Initiative (System of Care) and the Circle of Care grants. Mr. Hunt said the 1-year planning grant is available now for the System of Care grant and there is a 4-year extension implementation grant that is expected to be put out. Finally, he reminded the group that Tribes are the only ones eligible for the Circles of Care program, stating the current cohort ends in 2014.

C: (Delight Satter) If anyone is interested in applying for the grants referenced, reach out to Dr. Johnson for tips on applying.

National Institute for Occupational Safety and Health: Worker Safety and Health Outreach

Max Kiefer, MS, CIH: Director, Western States Office, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Denver Federal Center

Mr. Kiefer talked about the National Institute for Occupational Safety and Health (NIOSH), focusing his presentation on occupational safety among AI/ANS. He explained to the meeting attendees that NIOSH is not an enforcement agency, rather it conducts occupational safety research—they focus on keeping people safe at work. With labs throughout the U.S., NIOSH conducts epidemiology and surveillance to know the determinants and distribution of illnesses and injuries in the workplace. It also works closely with States to conduct specific surveillances. Mr. Kiefer informed the group that field response programs can be requested and are free to the requestor; and he said they also do fatality evaluations and investigate every firefighter fatality. Noting that laboratory research areas include engineering, chemical, physical, biological, and human studies, Mr. Kiefer said the Western States Office now serves as a gateway to address issues in the west, working closely with States in the west (where fatality rates are higher than those nationally). Among the Western States Office's initiatives cited by Mr. Kiefer included a new initiative to develop and implement a program to provide occupational and safety outreach to AI/ANS. He said an action plan has been developed and implementation is beginning, starting with identifying key partners involved in worker safety and health. He added that consideration is also being given to conducting a pilot technical assistance project to evaluate approaches to improve work safety and health among AI/ANS. All activities will be coordinated with the OSTLTS. After sharing statistics on worker safety and health in AI/AN communities, Mr. Kiefer shared various resources related to uranium mining; non-fatal injuries to youth; and

occupation health needs assessment for Tribes in New Mexico, as well as the NIOSH homepage. In closing, Mr. Kiefer asked for feedback on various discussion items:

- Is worker safety and health a priority in AI/AN communities?
- Are there ongoing activities in Tribal communities focused on worker safety and health?
- How can NIOSH best provide support to help keep AI/AN workers safe and healthy, e.g., direct field assistance, outreach and communication, surveillance, pilot projects?
- Are there groups we should work with?

Q: (Ramona Antone Nez) Are the transportation crashes related to the workers driving?

A: (Max Kiefer) It's a situation where driving is an extension of their job.

Q: (Jackie Kaslow) Are the figures referenced on Tribal lands or in general population?

A: (Max Kiefer) They are in the general population.

C: (Ryan Hill) The data is specific to AI/ANs, but they could be on or off reservations.

C: (Jay Butler) The statistics that you showed by State caught my eye. Thanks to NIOSH, in Alaska the worker fatality rate has fallen in the last 30 years. From an Alaskan perspective, one of the challenges is how we define worker safety. Is a whaler a job, recreation, or substance living? It's an area where you could intervene in not only worker safety, but also community safety. We don't have a lot of drowning among whalers, but risk is there. One Tribe created a White Float Coat program. The coats hold up better in the weather conditions; but the unintended advantage is the whalers are seen as heroes and their behavior is often emulated. What constitutes an occupation may not be entirely clear.

C: (Max Kiefer) That's a great point. Your example is great. They seem to be a worker to me, but making it categorical can be a challenge.

Q: (Jackie Kaslow) In California we have an example where recently a Tribal leader had a concern about environmental challenges. Trees were knocked over and there was a fear that elders might freeze, so community members were removing the large trees. The knowledge of doing that safely was brought up. Categorically, this bleeds over into other areas. Do you work with these types of topics?

A: (Max Kiefer) We do have an emergency response team and consider those who clear roads to be workers. We have done work in those areas. We are also concerned with fatigue, heat, cold, stress and other things that could be factors.

Q: (Jackie Kaslow) The same Tribal groups have no ambulance service. Are there resources in your framework?

A: (Max Kiefer) We could make strong recommendations; but we would not be able to provide that. We might be able to identify where those resources might come from.

Q: (Chester Antone) What is the protocol when you are asked to do a health hazard evaluation?

A: (Max Kiefer) We have 35 people in our program and we draw from other parts of the institute. A request can come from an employer, a union, Tribal leaders, or workers. We get confidential requests (we need three of them). You can make a request from our webpage.

Q: (Chester Antone) You mentioned transportation. We have a Health Transportation Division and we have a limited number of drivers. We are concerned about rotation schedules. Some work 7 days a week or more. It seems like that's not too safe. Do you do that sort of evaluation and make recommendations to prevent accidents from occurring?

A: (Max Kiefer) We have a center for motor vehicle safety. There are Federal regulations that limit the time of work. We've done studies on things such as lifestyle and engineering work with ambulances to protect the paramedic in the back. We do have an emphasis on reducing traffic related injuries. Ryan is working on providing feedback to the driver.

Q: (Chester Antone) In Arizona we have a large border control and a couple of checkpoints. The border patrol began to make a lot of its own rules. Have you ever gotten a request from the border control on how dust may affect their respiratory system?

A: (Max Kiefer) I know we got a request related to car emissions, from cars idling. We've looked at dust in other areas, but not for border control.

Q: (Max Kiefer) Are there jobs that are particularly hazardous? What do you see as emerging issues? What future problems can we help prevent?

A: (Chester Antone) One way to look at it is to know where Tribes exist and look at the environment of where they are. For instance, if Tribes are located near a mine, that's going to be something that they may deal with in terms of miner safety. There are other entities like border control that might present an occupational concern for workers and the community. In our area, we have a lot of distance between us, so the hazards might come from the environment.

A: (Lisa Pivec) Our Deputy Chief at Cherokee Nation is concerned about Tribal workers inside casinos. We may be reaching out for assistance in this matter; it's a sensitive matter. When the time comes, we will request assistance. We've had our first Tribal health assessment thanks to CDC, so we know lung cancer is a leading cause of death for our people.

Community-Based Public Health Engagement

Pierre Rollin, MD: Team Lead, Viral Special Pathogens Branch, Division of High-Consequence Pathogens and Pathology, National Center for Emerging Zoonotic and Infectious Diseases, Centers for Disease Control and Prevention

Craig Manning: Health Education and Communications, Viral Special Pathogens Branch, Division of High Consequence Pathogens and Pathology, National Center for Emerging and Zoonotic Diseases, Centers for Disease Control and Prevention

Barbara Knust, DVM, MPH, DACVPM, LCDR: U.S. Public Health Service, Viral Special Pathogens Branch, Division of High Consequence Pathogens and Pathology, National Center for Emerging and Zoonotic Diseases, Centers for Disease Control and Prevention

Dr. Rollin began the discussion by providing an overview of the Viral Special Pathogens Branch (VSPB). He noted that while most viruses come from overseas, some (like the hantavirus) originate in the U.S. Ms. Knust provided background information on the emergence of the hantavirus, carried by deer mice. She explained that despite the development of an educational campaign to educate people about the disease, the hantavirus claimed 32 lives (many on the Navajo Nation). Twenty years later, she said the hantavirus still occurs (617 cases to-date, 17 percent in AI/ANs predominately residing in western rural areas). With approximately 20-40 cases reported each year, Ms. Knust said there continues to be a need to educate at-risk groups. For his portion of the presentation, Mr. Manning discussed collaborations with the Navajo Department of Health and Diné College. He also addressed activities planned for 2013, among which include a video on rodent exclusion for the National Park Service; a Diné College public health course; and Grand Rounds that focus on hantavirus, Rocky Mountain Spotted Fever (RMSF), rabies, and other topics. Finally, he indicated that Mark Bauer, Diné College, will include in his Principles of Public Health course the making of a video for use by conventional and social media.

Q: (Chester Antone) You mentioned RMSF, do you know how it got into Arizona? I was told that it started in the Carolinas or further down in Mexico.

A: (Barbara Knust) We are not the experts on RMSF, so we can't speak to that.

C: (Delight Satter) We are contacting Jennifer McQuiston to see if she can come over, but if not we can invite her to a call or our next meeting.

C: (Barbara Knust) There are hantavirus cases from 1959. It probably has been present in the deer mouse for thousands of years. It took some people putting the dots together to discover it. With RMSF, the picture is changing very quickly. It's different in that way.

Q: (Chester Antone) You look at the map and see it began in the Four Corners area and now it's all over; how does it get transferred?

A: (Craig Manning) The animal control people in San Carlos are eager to share their experience.

C: (Jay Butler) The work the VSPB does is very important. Yesterday, we saw the story of Legionnaires disease and what is often forgotten is the amount of time it took for that information to come out. In terms of the health education aspect, I wanted to mention that a government-to-government relationship was obvious in dealing with the Navajo; that helped with getting the educational information out.

C: (Jackie Kaslow) California is affected by the hantavirus. Mr. Manning, what is meant by "exclusion of species?" We believe you don't eradicate the organism that is the reservoir, because you could upset the ecological system.

C: (Barbara Knust) It's a good point; a balance has to be struck. In terms of education, it's important to think about how people can protect themselves without wiping out a species that is in the ecosystem. In terms of prevention messages, the way we phrase it is "clean up, seal up, and trap up." So, when we talk about "exclusion," we are really talking about protecting the home from the rodent entering. We don't recommend wholesale removal of animals.

C: (Pierre Rollin) In Yosemite, there were cabins that were built to hold rodents and people. Yosemite had to destroy those cabins because the design was wrong.

C: (Ramona Antone Nez) In terms of an update to your visit to the Navajo Nation, I will support this project by issuing a letter to increase education and decrease the incidents of hantavirus on Navajo. I also hope we can increase our staffing capacity in terms of using our expertise in zoonotic studies as a key gateway into CDC. RMSF should be part of the Grand Rounds; and we can involve our traditional teachers in discussions on public health. They should be included in the Grand Rounds. I hope the team from Atlanta will take with them a part of the essential component of who we are as a Native community. At first I was hesitant about their proposal, because of the stigma from 20 years ago; but to move forward sometimes you have to look back. In the end we want to decrease the health disparities and we want health and wellness for our people. Thank you for your respectful approach thus far.

C: (Chester Antone) To the extent they want their traditional medicine person involved, that is their choice.

C: (Delight Satter) We look forward to the letter from the Navajo Nation. We will put on the schedule for next time to get a list of items for the Grand Rounds that CDC has; we do it every Tuesday via conference calls.

Q: (Jay Butler) Are the Grand Rounds archived?

A: (Delight Satter) I don't know; we can find out. We may have to work on the time.

Wrap-Up

Delight Satter, MPH (Confederated Tribes of Grand Ronde): Associate Director for Tribal Support, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

Ms. Satter thanked the TAC for its attendance and advice; and she expressed appreciation for the committee's passion, saying CDC welcomes its engagement. On the group's next call, she said they would address the following items: TAC recruitment flyers; feedback on Dr. Strickland's video trainings; format for the summer meeting; and the TAC issues tracking tool and prioritizing the items. Directing the TAC to the meeting binder (under Tab 5), Ms. Satter indicated that the TAC's input was requested on ideas about the Health is a Human Right Exhibit information.

Chairman Antone stated that the TAC would discuss the timing of the next meeting during its next conference call. Ms. Satter reminded the group that the meeting would need to occur in July or August, recognizing that various groups and stakeholders will have summer meetings of their own.

The Winter 2013 CDC/ATSDR TAC Meeting ended with Chairman Antone providing the closing blessing.

Appendix A: Participant Roster

Tribal Advisory Committee (TAC) Members

Delegates:

Cathy Abramson, Director and Member, Sault Ste. Marie Chippewa Indians

Chester Antone, Councilman, Tohono O'odham Nation

Michelle Hayward, Secretary, Redding Rancheria

Alicia Reft, President, Karluk Ira Tribal Council

Authorized Representatives:

Jay Butler, Senior Director, Community Health Services, Alaska Native Tribal Health Consortium

Jackie Kaslow, California Rural Indian Health Board

Ramona Antone Nez, Epidemiology Director, Navajo Epidemiology Center

Sandra Orgeta, Councilwoman, Tohono O'odham Nation

Lisa Pivec, Director, Community Health Promotion, Cherokee Nation

Other Tribal Attendees

Doris Cook, Consultant, Akwesasne Mohawk

Pamela Thurman, Director, Cherokee

Maylynn Warne, Program Director, Great Plains Tribal Chairmen's Health Board

Neva Zephier, Project Coordinator, Great Plains Tribal Chairmen's Health Board

Centers for Disease Control and Prevention

Katie Agin, Management Analyst, Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, Office of the Director

Annabelle Allison, Associate Director, Centers for Disease Control and Prevention, National Center for Environmental Health, Agency for Toxic Substances and Disease Registry

Larry Alonso, U.S. Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

Danielle Arellano, ORISE Fellow, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, Applied Science Branch

Jeneita Bell, Medical Officer, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Health Systems and Trauma Systems Branch

CAPT Holly Billie, Injury Prevention Specialist, Centers for Disease Control and Prevention, Office of Noncommunicable Diseases, Injury and Environmental Health, National Center for Injury Prevention and Control

Gail Bolan, Director, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention for the Division of STD

Letia Boseman, Senior Public Health Analyst, Centers for Disease Control and Prevention / Office of Noncommunicable Diseases, Injury and Environmental Health, National Center for Chronic Disease Prevention and Health Promotion

Gloria B. Bryan, Centers for Disease Control and Prevention, Office on Smoking and Health

Kimberly Cantrell, Deputy Associate Director for Tribal Support, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director

Pyone Cho, Epidemiologist, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, Epidemiology and Statistics Branch, Surveillance

Alex E. Crosby, Medical Epidemiologist, U.S. Public Health Service, Acting Branch Chief, Centers for Disease Control and Prevention, National Center For Injury Prevention and Control, Division Of Violence Prevention, Surveillance Branch

Denise D'Angelo, PRAMS Program Manager, Centers for Disease Control and Prevention, Office of Noncommunicable Diseases, Injury and Environmental Health, National Center for Chronic Disease Prevention and Health Promotion

Miatta Dennis, Public Health Analyst, Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, Office of the Director

Melanie Duckworth, Senior Liaison, Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, Office of the Director

Frank Ebagua, Public Health Analyst, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Capacity Building Branch

Arlene Edwards, Behavioral Scientist, Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, Capacity Building Branch

Kathleen A. Ethier, Acting Director, Centers for Disease Control and Prevention, Financial Management Office

Thomas Frieden, Director, Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry, Office of the Director

Bridgette Garrett, Senior Advisor for Health Disparities, Centers for Disease Control and Prevention, Office on Smoking and Health

Seth Gazes, Associate Director for Policy, Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, Office of the Director

Jessica Gershick, Public Health Analyst, Centers for Disease Control and Prevention, Office of Noncommunicable Diseases, Injury and Environmental Health, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, Office of the Director, Policy Team

Judith Giri, Senior Research Fellow/CASPIR Lead, Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services, Laboratory Science, Policy and Practice Program Office, Division of Laboratory Policy and Practice

Corinne Graffunder, Deputy Associate Director for Policy, Centers for Disease Control and Prevention, Office of the Associate Director for Policy

Jason Greene, Intern, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of HIV/AIDS Prevention, Intervention, Research, and Support, Capacity Building Branch

Ryan Hill, Environmental Safety and Health Specialist, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Office of the Director, Office of Administrative and Management Services

David Holmes, Director, Centers for Disease Control and Prevention, Division of Laboratory Policy and Practice

Wendy Holmes, Senior Liaison, Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support

Liane Hostler, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response, Office of the Director

Stacy Howard, Associate Director for Policy, Centers for Disease Control and Prevention

Holly C. Hunt, Branch Chief, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, School of Health Branch

Candis Hunter, Epidemiologist, Centers for Disease Control and Prevention, Office of Noncommunicable Diseases, Injury and Environmental Health, Agency for Toxic Substances and Disease Registry, Division of Toxicology and Human Health Sciences

Melissa Jim, Epidemiologist, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Noncommunicable Diseases, Injury and Environmental Health

Sherry Jones, Health Scientist, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of Adolescent and School Health

John Kastenbauer, Centers for Disease Control and Prevention, Office of the Director, Office of the Chief Operating Officer, Office of the Chief Information Officer, Management Analysis and Services Office, Federal Advisory Committee Management Branch

Max Kiefer, Director, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Western States Office

Barbara Knust, U.S. Public Health Service, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Diseases, Division of High Consequence Pathogens and Pathology, Viral Special Pathogens Branch

Christine Kosmos, Director, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response, Division of State and Local Readiness

Brock Lamont, Chief, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Immunization Services Division, Program Operations Branch

Amy Lowry, Public Health Analyst, Centers for Disease Control and Prevention, National Center For Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity, Office of the Director

Anne Major, Program Consultant, Centers for Disease Control and Prevention, Comprehensive Cancer Control Branch, National Center For Chronic Disease Prevention and Health Promotion

Craig Manning, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Diseases, Division of High Consequence Pathogens and Pathology, Viral Special Pathogens Branch, Health Education and Communications

Latisha Marshall, Health Scientist, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Epidemiology Branch, Office on Smoking and Health

Donna McCree, Associate Director for Health Equity, Centers for Disease Control and Prevention, / National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention, Office of the Director

Lisa McGuire, Team Leader, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Injury Response, Research Team

Jennifer McQuiston, Epidemiology Team Leader, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases

Amanda McWhorter, Planning and Evaluation Team, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response, Office of Policy, Planning and Evaluation

Judith Monroe, Deputy Director, Centers for Disease Control and Prevention and Director, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director

Georgia Moore, Director for Policy, Centers for Disease Control and Prevention and Director, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director

Mathew Murphy, Epidemiologist, Centers for Disease Control and Prevention, National Center for Environmental Health, Health Studies Branch,

Tracy Perkins, Public Health Analyst, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, CSSB, Preventive Health and Health Services Block Grant

Phyllis Nichols, Public Health Advisor/Project Officer, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion Division of Community Health, Program Development and Implementation Branch

Ann O'Connor, Program Planning & Advancement Chief, Centers for Disease Control and Prevention, Office of the Associate Director for Program

Patricia Patrick, Program Consultant, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Mathew Penn, Director, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director, Public Health Law Program

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Kirsten Rambo, Senior Service Fellow, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, Intimate Partner Violence and Sexual Violence Team

Pierre Rollin, Team Lead, Centers for Disease Control and Prevention, National Center for Emerging Zoonotic and Infectious Diseases, Division of High-Consequence Pathogens and Pathology, Viral Special Pathogens Branch

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Louise E. Shaw, Curator, Centers for Disease Control and Prevention, David J. Sencer CDC Museum

Gregory A. Smith, Tribal Liaison Officer, Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response, Division of State and Local Readiness, Program Services Branch, Applied Services Team

April Taylor, Public Health Analyst, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director

Myra Tucker, Tribal Liaison, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, Applied Science Branch

Jo Valentine, Associate Director, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention, Office of Health Equity

Joyanna Wendt, Epidemic Intelligence Service Officer, Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion

Craig Wilkins, Senior Liaison Officer, Centers for Disease Control and Prevention, Office for State Tribal, Local and Territorial Support, Office of the Director

General Attendees

Brenda Granillo, Director, Mountain West Preparedness and Emergency Response Learning Center

CAPT Andy Hunt, U.S. Public Health Service, Public Health Advisor, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child Adolescent and Family Branch