

**CDC/ATSDR Tribal Advisory Committee Meeting
8/12/2014
Grand Traverse, Michigan**

1

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AUG 12

Opening Blessing

(Not Recorded)

Welcome and Introductions

Director Cathy Abramson: At this time, I'd like to introduce Dr. Arias, who is the Principal Deputy Director for CDC and Prevention/ Agency for Toxic Substances and Disease Registry.

Dr. Ileana Arias: Good morning everyone. Thank you so much for joining us and welcome to the summer meeting of the TAC, the Tribal Advisory Committee. I'm incredibly excited to be here and joining you for this meeting. I'm very, very interested in dialoging with you throughout the day on ways that we continue to strengthen the relationship that I think we have developed and to continue to explore ways that we can help you and that you can help us essentially accomplish our mission. As you know, we work 24/7 to make sure that we save lives and protect the health of Americans and people throughout the world. Our goal is really to accomplish population health improvements and we cannot do that if we don't touch every community in this country in order to be able to do that. We have accomplished a lot. We have made significant impacts on population health in this country but if you look closely, that's not something that is true of everyone. Some communities are more likely to exhibit that kind of improvement; other communities are not. And our commitment is to make sure that we understand, number one, what are the needs of those communities that have not come as far as others and more importantly what needs to be done in order to make sure that they do benefit to the same extent that every other community in this country does as a result of the work that we and others do. I'd like to thank you for your time joining us and helping us to figure out how it is that we can do a better job of accomplishing that. I also want to thank our staff at the Office of Tribal, Local and Territorial Support and it's Tribal Support Unit for the work they've done in putting this meeting together and for the work that they've done to date in making sure that the relationship we've developed has continued to grow and strengthen and that it will continue to do so. In the past, we've talked about a number of topics that are of concern to us and a concern to you and your communities like motor vehicles, tobacco, sexually transmitted diseases, and others. We'll be talking about others that we haven't addressed to date and looking forward to your feedback on what it is that we can do in order to make sure that we empower you to be effective in your quests so that we can then also be effective in making sure that our agenda is complete. One of the

2

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things that we can always do is make sure that we provide the information that you need to make the choices that you need to make in order to improve the health of your communities. We also then make sure that we generate and create the tools that will help you do that. But none of those tools and none of the information is helpful if it actually cannot be put into the hands of people who can actually make a difference, and that's not us. So what we're really interested in doing is what's the information that you need, what are the tools that you need, and then what is it that we can do so that you can actually put those in the hands of people who need to make action in order to make sure that there is some benefit from that information and from those tools. So, again, I thank you for your time, for your partnership and your commitment to helping us make sure that again every resident of this country is as healthy as they possibly can be.

Director Cathy Abramson: Thank you very much and now at this time I would like to introduce Dr. Judith Monroe. She's the Director of the Office of State, Tribal, Local and Territorial Support, and she's Deputy Director at CDC. Dr. Monroe.

Dr. Judy Monroe: Thank you. So good morning everyone. It's great to see so many of you out this nice rainy morning, but I think it's so relaxing here so I just want to thank Cathy Abramson, Director Abramson and the Bemidji Tribes for hosting us. It's really wonderful to be here, and I understand it will not be raining tomorrow, correct?. But no it's really wonderful here, so thank you. I'd also like to welcome two of our new TAC members. We have school board member, Beverly Coho from Ramah Chapter of Navajo Nation, and we have tribal council member Delia Carlyle from Ak-Chin Indian Community. Good morning. So welcome. Welcome. We are really excited because we have 15 members on the TAC now. And I think we only have one seat left to fill so we're quite excited about that. So this really promises to provide us here at CDC some really valuable insight from all the tribes across the country, so very excited about that. And we - I do want to thank all of you for your public service and for what you're doing for public health for American Indian / Alaska Native Communities. I know it takes a lot to travel and to just make the meetings and so we want to give our sincere thanks for all of you for your wisdom and your advice as we move along. You know CDC does support tribal sovereignty and self-determination for tribal governments and we will always keep that foremost in our work. As Dr. Arias said, it's important that we continue to strengthen our relationship and partnership with the tribes so that we can help improve native public health. And so we look forward to meaningful discussions over the next couple of days. Again, welcome to everyone in attendance.

Director Cathy Abramson: At this time I would like to introduce Captain April Shaw. She is the U.S. Public Service Acting Director for Tribal Support Unit.

CAPT April Shaw: Good morning. Yes, I'm Captain April Shaw. I'm Acting Director for Tribal Support Unit and I also wanted to extend a warm welcome to the TAC members, to other tribal leaders and tribal elders as well as our other guests. I'm looking forward to spending the next few days with you and enjoying this beautiful area. Even though it's rainy it's still so beautiful out there, so I'm looking forward to that. I need to provide a few logistic kinds of information for you just to let you know and make you more comfortable on the surroundings. So I wanted to let you know there is water available in the room. There are two tables on either end of the room with water. Also, there's a Starbucks across the lobby for those that like coffee – I see some of you have already made your way over there – coffee or hot tea. As well as there are restaurants located throughout the hotel, and in your binders under tab 15, there is a listing of all the different restaurants that are in the hotel. For those of you that are going to use a federal government credit card, please stop by the registration table for some important instructions about using your government credit card at different locations in the hotel. There's a little bit of a – kind of a trick to it - so please make sure you stop by and ask for instructions about that. Also, I wanted to make you aware that there is a special interest session that's going to be held following the conclusion of the meeting today, and it's going to be presented by CDC's Office of Smoking and Health and I know I sent out a sort of an inquiry to find out how many TAC members were interested in attending and I think many of you did show interest. So it will be held in this same room from 5 to 6pm this evening, so please consider attending. Also, if you brought handouts that you would like to share – if you're a presenter or just information that you want to make available to others – we have a resource table located in that back corner over there, so please leave your information there so that others can help themselves to that. Another important handout that can be found in the front of your binders is called "A Guidance for Public Attendees", and it outlines the protocol that should be respected over the course of the next two days. So I'd like to especially highlight a few of the guidelines for everyone. During today's meeting and tomorrow's formal consultation session and formal tribal testimony, only TAC members, CDC senior leader, and if space permits, other elected tribal leaders or their authorized representatives, may be seated at the table. And members of the public may not speak during meeting proceedings. Out of respect for the proceedings of this meeting, we would like to ask that attendees not enter or leave the room during the opening and closing blessing or during formal tribal testimony. And also, the disclaimer always has to be said - please make sure your cell phones and laptops and other electronic devices are silenced or turned off during the meeting. So please look over this handout for other important information about attending this kind of a meeting. And just as a reminder for all TAC members, authorized representatives and CDC leadership – please remember to state your name before beginning to speak because the sessions are being recorded for the purpose of transcribing the minutes.. So now that all the logistics are out of the way, I just wanted to let you know that my staff here, the Tribal Support Unit, are

4

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really looking forward to serving you and making you feel very, very comfortable during this meeting. If there is anything that we can do to make your stay more comfortable, if there are any issues that you encounter, please let us know and we will do everything we can to make this a really great meeting for you. So we're looking forward to spending time with you. Thank you very much.

Director Cathy Abramson: At this time we'll go around the table first introductions and then we are going to go around outside and everybody can stand up and introduce themselves.

Chairman Robert Flying Hawk: Good morning. My name is Robert Flying Hawk. I'm the Chairman for the Yankton Sioux Tribe in South Dakota. Good morning.

Lt. Governor Jefferson Keel: Good morning. My name is Jefferson Keel. I'm Lt. Governor of the Chickasaw Nation.

Council Member Patty Quisno: Good morning. I am Patty Quisno, Council Member from the Fort Belknap Tribe in North Central Montana.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) A good morning. My name is Badger. This is my first meeting. I'm glad we're doing introductions. I know a few people in the room and I'm glad to be here. I'm Council Member from the Confederated Tribes of the Colville Indian Reservation and also chair the Northwest Portland Area Indian Health Board and sit on the National Indian Health Board.

School Board Member Beverly Coho: Good morning. My name is Beverly Coho. I'm a member of the Ramah Band of Navajos. I'm Elected School Board Member who runs a health center. Also, I'm a member of the Albuquerque Area Indian Health Board. Thank you.

Council Member Leslie Sampson: Good morning. My name is Leslie Sampson. I'm an Alaska Delegate and this is my second meeting.

Ramona Antone-Nez: (Speaks in Native language.) I'm Ramona Antone-Nez and I'm an authorized representative for Navajo area. I would like to also send my greetings from Vice President Rex Lee Jim who is not able to attend today.

Secretary Shawn Gavin: Good morning everyone. I'm Shawna Gavin, General Council Secretary from the Umatilla Tribe, and I'm also the Treasurer on the Northwest Portland Area Indian Health Board.

Chairman Herman Honanie: (Speaks in Native language.) Herman Honanie. Chairman Hopi Tribe in northeastern Arizona. I'm a member of the Hopi Tribe and a member of the Tobacco clan and I'm very happy to be here this morning. (Speaks in Native language.) Thank you.

...Audience members stood up and introduced themselves.

Tribal Advisory Committee (TAC) Business

Director Cathy Abramson: Thank y'all for being here and thank you for coming. At this time, Romana Fetherolf will be doing the roll call.

Romana Fetherolf: Good morning. Alaska area. Albuquerque area. The Bemidji Area. Billings area. Great Plains area. Nashville area. Navajo area. Oklahoma area. Phoenix area. Portland area. Tucson area. At-Large Hopi Tribe. At-Large Kickapoo Tribe in Kansas. At-Large Confederated Tribes of the Colville Reservation. At-Large Noorvik Native Community. Thank you.

Director Cathy Abramson: Okay, so we obviously have folks here... so that means we need to have more meetings here. As tribal reps we work with the CDC/ATSDR staff to exchange information about public health issues in Indian Country, and identify urgent public health needs and discuss collaborative approaches to address these issues and needs. So in addition to assisting in the planning and coordination of tribal consultation sessions, we advise them regarding the government-to-government consultation process and help ensure that CDC activities or policies that impact Indian Country are brought to the attention of all tribal leaders. So I've been on this committee—I'm not quite sure how long but a number of years where I've seen a real good change and it's strengthened a lot and I really believe it has a lot to do with...under the leadership of Dr. Monroe. Dr. Monroe has been making a great effort to come out to Indian Country and get to know us, and that's good but we're not all cousins across the Indian nation, and we all have various issues/ different issues and she's getting to know us for who we are and in our areas of different needs. Some are very similar while others aren't. So I appreciate that and I'm very glad she's here. Actually, I'm glad you're all here. So that's what we do and it's up to - I have talked to some tribal members, tribal - various tribes and their concerns and I think what needs to be done more on tribes' part is their people need to contact their committee members and give them information that we can bring here because they need to help us out by giving the information to us so that we can bring it here so that we have it recorded and that the staff from CDC can see what they can do in helping us either resolve an issue or how they can work with the tribes or they either can or they can't, but will give an answer. So that's what

we need to do. And there are monthly phone calls that TAC members...we really need to become more active and get on those phone calls as much as possible, and I think that's the way it's gonna be for a lot of committees that we do just have to get on the phone calls. So very important because of budget-wise. We're not always going to be able to travel. I think we meet quarterly - twice a year? Twice a year.

CAPT April Shaw: Hello. Also, I wanted to make sure that the time and date of those monthly calls is the best time and date. Since the participation has been a little bit lower, we wanted to make sure that it was still a convenient time. So if there are conflicts that arise you know every month that you can see that this is not a good date and time, please let us know and we're happy to change that.

Director Cathy Abramson: For the advisors unfortunately, it's not paid for. So got to be creative there. But they're very, very helpful. And at this time, I would really like to give Lisa Abramson great kudos for helping arrange this, helping out plan this and getting things going. She worked a lot for putting this together with the staff and CDC. (blank for several minutes 32:25 – 34:49)...of how grants are written so that tribes qualify for these grants because a lot of times they're not written in such a way where tribes can apply. So there's many different issues. Liz Carr is here from HHS and she wanted to get up and say a few words. I warned her I was gonna pick on her.

Elizabeth Carr: Good morning, again, everybody. On behalf of the newly appointed Secretary Burwell, I would like to welcome you to Traverse City and the CDC TAC meeting. Like Cathy said, a lot of issues are brought up at the STAC and CDC is one of those things that continues to come up, and we always have great senior leadership from Dr. Monroe there to listen and bring back the concerns to the agency. So we really appreciate her support. Recently we had the STAC visit the CDC and I think it was a really great turnout and a really great experience. I think we learned a lot. I don't think we expected to learn that much and we really appreciated the tours as well. We had great senior leadership support there as well. The senior leaders from each of the- what are they called- the centers were there giving us updates on the work that they do that is in relation to Indian Country so I think it was a really great experience. They are doing a lot of work behind the scenes that we're just not aware of and so that's my update for today. If you guys have any questions about the STAC specifically, I'm here all week, so thank you.

CAPT April Shaw: Good morning. In keeping with what I said, I'll announce my name, April Shaw, for the recording purposes. So good morning again. Over the next few minutes, I would like to discuss the Issues and Recommendations document. This is something that was sent out to the TAC members a little while back and hopefully you've had a chance to review it. The discussion this

morning is that I wanted to let you know the process that the Tribal Support Unit went through to create the document and to get your feedback. Since this is the first time that the CDC Tribal Support Unit has produced this, we want to make sure that we meet your needs and expectations so your feedback is really important to us, as well as to check about some timelines and see whether these timelines seem reasonable. So to provide a little background, it was felt by TAC members that oftentimes questions and issues would be raised at the different meetings and they felt that they were not getting the feedback, the responses back from CDC. So in an attempt to be more responsive, CDC created this process. So at the winter TAC meeting, we took all the issues, questions and recommendations that the TAC members submitted and we brought those back to CDC and then gave them to the different centers, institutes and offices to filter down to the subject matter experts that could speak to this topic. So, for example, if a question might have come in about diabetes, then it might have likely gone to the National Center for Chronic Disease Prevention Health Promotion. That would be an example. So then we took the responses provided by all the subject matter experts and we consolidated it into the one document which is called the Issues and Recommendations document, and then we have sent it to you for your review, as I mentioned. So going forward we wanted to solicit your comments at this time about the process; not specifically about what the content is; however, if when you look over the document, you do have further questions or comments, we're happy to take those back and reach out again to the subject matter experts for further clarification or more information. But at this time just to get your feedback on was the document easy to go through, to read, was the format okay for you, and did you have an opportunity to review it before the TAC meeting, did you have sufficient time. Just some feedback around those kinds of things and then also just what your input is as far as when we should sort of have a cut off for the issues and questions to be included within each of the different editions. So at this time I'd like to open it up to you to give comment back on some of those questions or ask any questions that you might have. Also, it's located behind tab 9, the Issues and Recommendations document. If you haven't found that yet, that's where it's located. And just as a side note, if there is a question that you remember that you asked and you don't see it appearing in this edition of the document, it may be that we're still researching it and the answer, the response will be in the next Issues and Recommendations document if we're still researching.

Ramona Antone-Nez: Ah yes, I have two comments.

CAPT April Shaw: And please remember to state your name before you respond. Thank you.

Ramona Antone-Nez: Ramona Antone-Nez, Navajo Nation. Captain Shaw, thank you for your introduction on this document. I do want to say thank you to

the OSTLTS staffing for seeing this. I see this as an improvement to address the issues that are brought up and the recommendations that are made. What, how important the monthly calls are, this was introduced to the TAC members via email approximately 2-3 weeks ago for us to have the opportunity to make review to the document, and also during the call itself we had that opportunity. So just wanted to make that comment that this is an improvement from the recommendations that were made. So I just want to acknowledge that and acknowledge Dr. Monroe for making this critical improvement because I think what will happen is we'll start to see additional changes.

CAPT April Shaw: Thank you very much and did you have any comment about the format at all? Did you find it easy to read through?

Ramona Antone-Nez: Thank you. My comment is that it's thorough and it seems like the note taking is very well done. I don't have any recommendations at this time in terms of the formatting as the—not bad for the first round. Thanks.

Chairman Herman Honanie: Good morning. Herman Honanie, Chairman Hopi Tribe. I just really wanted to say something similar to what she said because I missed out on the first call because I just didn't have the time. And so my question to you is there's gonna be oftentimes that I'm not directly available to get on those calls so I was wondering if my chief of staff, someone within my office could be able to sit in on my behalf to take the necessary information and maybe provide feedback if and when we do have a review ahead of time with such issues that are presented prior to the calls.

CAPT April Shaw: Would that be your authorized representative or somebody in addition?

Chairman Herman Honanie: Well, at this point I'm just thinking of someone within my staff because it would just depend on my authorized individual's availability as well, and come to think of it, I need to think a little bit more about that point on the authorized representative who could speak on my behalf.

CAPT April Shaw: I think someone is scribbling a note back there to tell me the answer, so hold on one minute.

Chairman Herman Honanie: Okay. The other thing in general is we're always interested in funding to the various programs within CDC so maybe that's just my general question or statement that there are so many things happening in this country and with the federal government and we always seem to come up against the point whether when we do ask for additional funding for respective programs, it seems very, very far and in the distant future that we ever get an

increase in funding. So I'm just wondering the point of negotiating on grants or especially contracts. What is the future of funding at this point in time?

CAPT April Shaw: I know that in my updates I'm going to go over some funding opportunities that have just gone out and I'm gonna go into them in some detail. And I think Dr. Monroe may be addressing that in her talk tomorrow as well, but I know that CDC does strive to improve the language around writing the proposals in order to make it possible for tribes and tribal serving organizations to apply as often as possible. Did you want to comment?

Dr. Judy Monroe: Yeah, I think - we're gonna go over some detail of direct funding. We do have more direct funding available for tribes but it sounds like your question was a more general—a larger question about funding in general and that, of course, has to do with CDC's budget at large.

Dr. Ileana Arias: So with this funding in general, I think, you know, none of us can say what's gonna happen in the future. All I can say is we have been significantly effective in the last couple of years in terms of making a case for public health generally and then for specific things that we have identified as priorities for all of us such as the prescription drug overdose issue, the smoking issue, and several of those. So we continue to get significant support from Congress and the administration for that work that we want to do and it's looking good. It's not—given the overall financial situation, it's not like there's gonna be significant amounts of new money coming in but we are seeing significant growth; growth that we had not expected we would have seen, given how difficult things were. So that speaks to the—I think the success of the work that has been done at CDC but also the success of the work that has been done by our partners with the money that CDC has provided in order to address the issue. So I think that if we continue to strive to making sure that effective programs are implemented in ways that actually are going to have the impact that everybody wants to have we'll continue to get that backing and continue to get that support on budget issues.

Lt. Governor Jefferson Keel: Could I say something? When we talk about funding in general, realizing that we're talking about the national budget issue, but coming back to the report and looking at what tribes are doing in local communities and how they're utilizing funds that's already available, there are some things that are not being reported (I'm trying to get it out) in a way that CDC understands really what's taking place in the community. And I think sometimes that's just a matter of the report format, and I'm not saying it needs to be changed or modified, I'm just saying there are activities that are taking place within local communities that CDC may or may not be able to assist with or fund in the future. But, you know, when we talk about the budget overall, we're talking about continuing resolutions, CR's in the next few months, so we may not see

any type of change or increase until you know the spring, which is typical. So I think it may be when we talk about assisting tribes more directly, maybe we go back to the block grant funding that goes to the states and how they're utilizing those and how tribes are able to access some of those funds that are supposedly, they're supposed to get to the tribal communities anyway but they're not. So we need to talk about some of those issues.

Dr. Ileana Arias: That's an excellent point and it's a combination of the two. One is the overall budget and then as Judy was saying, can we identify new ways or different ways of making sure that there's some direct funding to the tribes in that general issue whether it's finding out what's already being done or what the mechanisms that are available that can be tailored so that it does reach you know tribal communities.

Dr. Judy Monroe: With that, too, more comment as well. At CDC, we are looking at more accountability—when funding does go to the states, we don't always see then who gets funding beyond that and we are looking at mechanisms. I think there's some new—PGO is gonna have some new tools to be able to do that.

CAPT April Shaw: And to answer Chairman Honanie's question, so your authorized representative is the person that could sit in the meetings for you. So just for everyone's information, we meet there Monday at 2:00 p.m. eastern standard time currently. And we do have a template that we can send out to everyone so that you can list the information for your authorized representative, so we can provide that from our office and you can assign someone as well as if you need someone to sit in for that meeting just for that temporary meeting, send us an email ahead of time and let us know that that person will be taking notes for you so that they can bring the information back to you. So I wanted to ask if there was anyone else that had any comments about this Issues and Recommendations document, again, about did you have enough time to review it before our meeting and also we were going to propose possibly 30 days as the cutoff. So, for example, at the conclusion of this meeting, 30 days from that point would be the cutoff where you could still submit any questions or issues for it to come out in the next document. So then after that, then that would just be for a document in the future. So you can always submit questions and such to us but just to come out in the next document we were proposing that the cutoff maybe be 30 days after this meeting, or we're looking for your feedback on that.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) My name is Badger, Andy Joseph, Jr., from the Colville Tribe and my tribe has a reservation that's 1.5 million acres. That's the south half of the reservation. North half goes clear up into Canada and it doubles in size. You know our people are scattered amongst the whole range of land bigger than some states. You know, on funding, I'm not going to...I think funding should be sent directly to tribes and not

be passed through the state. I'll use the H1N1. When that first came out, it went through the state and hit the counties and the people that were supposed to be served first were the young ladies that were pregnant. My daughter was carrying at that time. She had to go across to a different county. If you look at the Robert Wood Johnson report, you know the two - two of the poorest counties in the United States health-wise are on the Colville Indian Reservation. And to me, I think the people in the county were so afraid of the sickness that they served their own people first. One of our schools that are on our reservation was served by a county across the river, and to me that's just totally not right. Our children should've been first. Right now we're being devastated by fires and you know IHS is so poorly funded some of our programs that were 638 that we contract out, like our public health nurses, they had to dig in their own pocket to get supplies to you know I guess fight infection, try to keep the disease from spreading. You know to me, it shouldn't be that way if we were directly funded, and I would say to use the IHS system on how they spread out the funding. The Portland area where we're from we don't have hospitals, and to me that's something that costs you know some of our people's lives not to respond as they should. So there's a different rating score system that IHS gives to areas that don't have hospitals, and to me I think it would be a better way to look at how to spread the money out. These public health nurses, they need to be able to have access to the tools you know that they were trained in. Thank you.

School Board Member Beverly Coho: Speaking to the issue here, my name is Beverly Coho from the Albuquerque area. I find that any feedback in creating a sincere dialogue is very meaningful and considering that I'm new, I haven't read the document but my first impression is that it is certainly useful. I can use it to orient myself as a new member; also to share with my fellow colleagues, and also to find some way to formulate some meaningful input to my roles and responsibility here. Your question on process is that it appears to serve the purpose of meaningful communication, then ultimately finding some answers. Thank you.

Director Cathy Abramson: Okay, before we go any further, can we vote on the form that they've used and see who requests a motion and support to see if you like - if you approve of the format that is being used.

Ramona Antone-Nez: I do want to make a recommendation before the motion. I had taken a better look in terms of the formatting. The recommendation that I have is there's major categories under which the questions or issue is brought up. One example, the first one is funding and as we look through the document, the next one is CDC organization, etc. My recommendation is right up front there, right underneath the italicized to perhaps start a table of contents, if you will. This is a 20-page document to start with and just to capture what the highlights are perhaps funding is page 1 through 5 and then the next CDC

organization is page 7, etc., just so that if you are interested in one particular topic, we could just get to that page and start from there. Perhaps even under the main heading of the start of the page you could go into the questions. Well, some of these questions are long, but I'd like to just make that first recommendation in terms of the highlights to start with, as a starting point. Thank you.

CAPT April Shaw: Okay, so thank you for your comment. So just to make sure, to clarify, so your recommendation is that we take the headings and we put them sort of in the table of contents in the very beginning of the document and refer to the page number or page numbers where that particular larger heading would be found. Do you want that to be alphabetized as well? Would that be helpful, do you think? Because I noticed it isn't.

Ramona Antone-Nez: This is Ramona from Navajo Nation. I'm not really sure about alphabetizing or even how you're gonna prioritize in terms of whether one issue or another. But that sounds like a good idea, too. Thank you.

CAPT April Shaw: Thank you very much. One last call for comments. Yes?

Lt. Governor Jefferson Keel: Let me just make sure I understand what we're talking about. I'm just clarifying that you're wanting to categorize, put these things in a table of contents by category, not necessarily by priority. Okay.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) I like the idea of having, going through, having those categories. To me, I guess I'm not sure how much time we would have to respond to any of these issues. I know as a tribal leader, we have all the different departments just as a congress, then there's senator or even the President of the United States, and they have special staff that are able to advise them and keep them up on the issues. I might be in a law and justice meeting one day or road safety or it could be a you know just a government, who's running for Congress kind of day or whatever. Being a tribal leader we have all these different responsibilities so to me I would hope that we would have the amount of time to respond on these issues. It would give us time to seek our advisors that are experts in the area, whatever topic it is. That way, when I come back here or if I'm on one of those conference calls, I'll be able to weigh in a little better. Thank you.

Director Cathy Abramson: This went out three weeks before so people could get time to respond.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) Just trying to follow the rules and say who I am. Anyway, I guess maybe once I get used to being an advisor for this committee, I do think that it sometimes it takes time for

our staff to study these issues and think them out thoroughly so that we can make sure that we're giving the right input. That's all.

CAPT April Shaw: Thank you for your comment. April Shaw. Just to clarify a little bit, when you receive the Issues and Recommendations document back, like you did just now, we were asking for you to review the process in general, to see whether the timeframes worked for you. But as far as the content of our responses to your questions or issues, those can always be clarified in the future. So, for example, if there's something that your staff helps to review and would like more information on, you're welcome to always ask for more clarification and we will send those back to the subject matter experts at CDC/ATSDR. So really we were just looking for did you have enough time to sort of review it before you came to the meeting to see if there was something that you wanted to discuss at the meeting. But we're always welcoming any other comments. So I think Director Abramson is going to take a vote now.

Director Cathy Abramson: Is there a motion, does somebody want to entertain a motion to accept this format along with a table of contents. Okay. Beverly?

School Board Member Beverly Coho: I like to make a motion that we accept this format on feedback leaving room for improvement, and then to include the comment that was made, recommendation to establish a table of contents. My name is Beverly Coho.

Lt. Governor Jefferson Keel: My name is Jefferson Keel. I second the motion.

Director Cathy Abramson: Second by Jefferson Keel. All those in favor, signify by saying "I". Those opposed? Any abstentions? Great. It's not on our agenda but we do need to vote on the minutes from the last meeting. So what would you like to do at this time? Is there a motion—does anybody want to entertain a motion to approve the minutes?

Lt. Governor Jefferson Keel: This is Jefferson Keel. I move we accept the minutes.

Director Cathy Abramson: Motion by Jefferson Keel to accept the minutes.

Secretary Shawn Gavin: This is Shawna Gavin. I second.

Director Cathy Abramson: Second by Shawna Gavin. All those in favor, signify by saying "I". Those opposed? Any abstentions? One abstention by Andy Joseph. Motion carried.

CAPT April Shaw: April Shaw. At this time I would like to take nominations for a chair that will serve on our Tribal Advisory Committee that will be from this meeting for one year time to the following meeting next summer. I do know that I spoke with Chairman Antone and he is interested in being the chair again if someone would like to nominate him. So I just put that out to you that he is interested. We would also like to entertain nominations for a co-chair because as we see, Director Abramson was very kind to step up and to do this for us today, but I think we are in need of a co-chair and so we would like to entertain for both, nominations for chair and co-chair at this time.

Chairman Herman Honanie: Herman Honanie. I would like to nominate Chester Antone to continue to be the chair.

CAPT April Shaw: Thank you. Any other nominations for chair?

Ramona Antone-Nez: Ramona Antone-Nez, Navajo Nation. I just want some clarification. The clarification I would like to ask is, is this the same as a co-chair and a vice chair? Is that the same roles and responsibilities and would there be any influences in terms of chairing a different Tribal Advisory Committee such as the TAC? Thank you.

CAPT April Shaw: Could you just clarify the very last thing you said about—

Ramona Antone-Nez: Would there be an impact to chairing other advisory committees?

CAPT April Shaw: Liz Carr, can I ask for your input on that?

Ramona Antone-Nez: Would chairing or co-chairing impact different other Tribal Advisory Committees?

Liz Carr: Sorry, are you asking in regards to being nominated and accepted to other Tribal Advisory Committees throughout the department? Is that your question? Or is it influencing the discussion at the Tribal Advisory Committee meetings?

Ramona Antone-Nez: So my question is if a person is chairing or co-chairing this particular advisory here, will that impact a different advisory committee?

Liz Carr: No, it should not.

Ramona Antone-Nez: Thank you for the clarification. The other clarification I have is a chair for this TAC. Is that equal to or the same as a co-chair or are

they different, because you're looking for two nominees, one chair and a co-chair. Is that equal? Thank you.

Liz Carr: So the way we do it at the STAC which is the Secretary's Tribal Advisory Committee is it's a chair and a vice chair. The title co-chair is a little bit misleading. We do it as a chair and a vice chair so when the chair is unavailable, the vice chair will chair the meeting. But otherwise it's a chair and a vice chair. Does that clarify your question? Great.

CAPT April Shaw: So I stand corrected. I'm calling for nominations for a chair and a vice chair. Thank you for the clarification.

CAPT April Shaw: So far I have the current chairman, Chester Antone as the nomination. Would anyone like to nominate someone as a vice chair?

Director Cathy Abramson: I would like to nominate Lt. Governor Jefferson Keel.

CAPT April Shaw: So Lt. Governor Jefferson Keel, would you like to accept the nomination?

Lt. Governor Jefferson Keel: Thank you. Thank you, Cathy. I will accept. I hope Chester is here next time.

CAPT April Shaw: So at this time I would like to see a show of hands for all in favor of Chester Antone as the next – the following year's chairman of the CDC Tribal Advisory Committee. All in favor say "I". And all opposed? And uh...Then I'd also like to...All in favor of – sorry, this is the first time I've done this – all in favor of Lt. Governor Jefferson Keel as the vice chair, say "I" if in favor. Anyone opposed. So congratulations to Chairman Chester Antone. And also Lt. Governor Jefferson Keel as our Vice Chair.

Lt. Governor Jefferson Keel: I think it's effective after this meeting.

END. (BREAK)

CDC's Tribal Support Unit Update

Director Cathy Abramson: They're yaking so much...I know (laughter). Okay, we're going to get started. I hate to break up all the fun and laughter, but we have to. Actually I was prompted – I was having a good time, too. At this time we will have Captain Shaw do a Tribal Support Unit update. And before I go any further, I just wanted to explain, I know there's some people that might have a little confusion about the meeting. The first part of the meeting is - we conduct our business, the Tribal Advisory Committee conducts business with the staff and

then tomorrow we will have our tribal consultation and that's when other people will have an opportunity to get up and bring some issues, and that's on your agenda. And if you don't have an agenda, there should be some on the registration table. So, ok.

CAPT April Shaw: Good morning again. April Shaw. I just wanted to sort of put a disclaimer out there that if you have questions that you want more information about as I'm going through my update, I'm in an acting role and I've been in the role for about two months, and so if I don't have the answer, I am happy to take the question back and get the information for you. So I probably won't be able to answer everything but I will do my very best and anyway, we'll go from there. So, I wanted to provide some Tribal Support updates and this is some of the members that support all the actions and the different activities with our Tribal Support Unit. So I wanted to point out that some of the people are here with us now under the Tribal Support Unit staff. Miatta Dennis is sitting behind me here. She's a public health analyst, and you may have spoken to Miatta before, arranging your travel or helping with the logistics for this meeting. She's usually on the monthly TAC calls as well. And April Taylor isn't here because she's getting married the end of this week, so she's gonna be having a big event in her life. But she helped a lot with also coordinating the meeting and she's always on the monthly calls and she's great at supporting all the different kinds of activities. We also have three new additions to our Tribal Support Unit and one of them is here, Romana Fetherolf is back over here taking notes feverishly and she's the one that did the roll call as well. We also have Deon Peoples and Alleen Weathers who are back in Atlanta supporting us as we're here. They are called PHAPs, and it's the Public Health Associate Program that is for—and Dr. Monroe will go into this a little bit more tomorrow, I believe, in her talk, but they're individuals that have graduated recently and want experience in the public health area and so they come to a two-year program so we're really happy to have them join our program. This is more of the staff that support our activities and communications and data management. And so I just wanted to give a big thank you to all of the staff that helped to put this meeting together and that support all the different kinds of activities that we do all the time, whether it's a TAC call or whether it's to send out information or to send out the minutes. So I would just like to show my appreciation and thank our staff.

So to go on with some recent and current activities, as we already discussed, the first Issues and Recommendations document was completed and was sent out to you. And again, we were happy to get your feedback. Going forward we're going to be writing the SOP or Standard Operating Procedure, but we're always - we can always update that SOP as well. But we're looking forward to the issues and recommendations that come out of this meeting to put together some more information and get you some more responses. Two additional TAC members were recruited, as we already mentioned, and so I wanted to formally welcome

from Albuquerque Area, School Board Member Beverly Coho. Thank you so much for being able to be here. From the Phoenix Area, Tribal Council Member Delia Carlyle was not able to make the meeting. Hopefully, she'll be on our next monthly call and you'll be able to meet her in that way. The coordinated Secretary's Tribal Advisory Committee visit, you heard a little bit about it from Liz Carr. I wanted to share a little bit more about the experience. I learned a lot as well. Even though I work at CDC, you know, we don't all know what we do every day in our different activities. So basically, as Liz described, we began with a meeting that was with the CDC senior leadership, which I think Dr. Monroe is going to go into that in a little more detail tomorrow, where they had an opportunity to sit down with the STAC members. And from there, we visited the Emergency Operations Center which provides up-to-date status on global situations such as Ebola and other kinds of emergencies. From there, we toured the TB lab, where I learned some startling results like there are 9,500 cases of TB in the United States; one-third of the world's population is infected with TB; and there are 8 million cases globally per year. I was really surprised to learn those facts. But we toured the TB labs and we saw the equipment and the different kinds of conditions that are required to work with that agent, so it was a very interesting lab tour. From there, we showed the STAC our - one of our great buildings called the Chamblee Environment Health Lab which received the LEED award which is Leadership in Energy and Environmental Design. It was interesting because the plants that surround the building are watered by a tank underground that holds 30,000 gallons of water and that water comes from the air. Basically, everyone's heard that humidity is high in Atlanta. Well, the air handlers that filter out the air collect the condensation and it goes into a 30 gallon tank underneath and waters those plants, so it sustains it, so it was pretty interesting. And we finished up with a smoking lab tour, where we saw things like 20 commercial cigarettes being smoked by a machine that collects the tar and nicotine for analyzation later on, and discussions around things like the E-cigarettes and the smokeless tobacco. So all in all, I thought it was a pretty informative tour.

The National Indian Health Board Tribal Public Health Workgroup met in February of 2014, as well as yesterday, and the NIHB received a five-year umbrella cooperative agreement to coordinate tribal public health workgroup to provide subject matter expertise and advice to the Tribal Advisory Committee and the CDC. In July, Dr. Bauer, who is going to be presenting in just a bit, the Director for the National Center for Chronic Disease Prevention and Health Promotion, and one of her staff and myself from OSTLTS Tribal Support Unit visited the Wind River Reservation. This was coordinated by Robert Foley with NIHB. Thank you, Robert. He's in the audience. And it was a really great opportunity to visit two tribes, both the Northern Arapaho and the Eastern Sheshoni that live on one reservation, the Wind River Reservation. So we visited programs such as the CHR program and WIC, the Tribal Fitness Program,

Diabetes Program, the White Buffalo Recovery Center Program, which deals with addiction problems and substance abuse. And we participated in a horse culture activity which was really interesting, which is basically around using the activity, the horses and nature to sort of come to an understanding of what's important and just being able to share fears, and it was around positive mental health and it was a really interesting and – it was a good activity. But the highlights of my trip were the first and last event where the tribal health director for the Northern Arapaho Tribe set up a sweat for us. So we got to do a sweat lodge for four hours which was pretty intense and pretty amazing, so we participated in that. And then the last event was we visited with a tribal elder that I believe she said she was 92 years old, who manages the Growing Resilience Community Garden Program and she's still working in her 90's. An amazing woman. So that was really great, too.

We are in the process of hiring a new CDC Associate Director for the Tribal Support Unit and the selection will hopefully be made before September, so you will see a constant face at these meetings instead of, you know, us that are doing our best to do the acting role, there will be somebody there to provide some good strong leadership. And I wanted to let you know that if you hadn't heard, that in FY 2014, the National Center for Chronic Disease Prevention Health Promotion announced three new FOA's. Awards will be made by September 30th. Just a few highlights. The first one, a Comprehensive Approach to Good Health and Wellness in Indian Country aims to prevent heart disease, diabetes, stroke and associated risk factors in American Indian tribes and Alaska Native villages through a holistic approach to population health and wellness. So funds will support approximately 12 American Indian tribes and Alaska Native villages directly, and approximately 12 tribal organizations, one in each of the 12 IHS administrative areas to provide leadership, technical assistance, training and resources to American Indian tribes and Alaska Native villages within their IHS administrative areas. The second funding opportunity was partnerships to improve community health, and this is to improve health and reduce the burden of chronic disease through evidence and practice base strategies to create or strengthen healthy environments that make it easier for people to choose and make healthy choices and to take charge of their health. And of the estimated 30 to 40 cooperative agreements that will be awarded, 5 to 10 will fund tribes and tribal organizations. And then the third funding opportunity, Racial and Ethnic Approaches to Community Health, or REACH, focuses on racial and ethnic communities experiencing health disparities. And the object of this project will support policy system and environmental improvements in those communities to improve health and reduce health disparities. So I wanted to make you aware of those. Again, they'll be - hopefully funding will be awarded by September 30th of 2014.

Also, CDC and IHS and SAMHSA, or Substance Abuse and Mental Health Services Administration, are hosting coordination calls or participating in coordination calls. One occurred just this past week and the calls are looking to coordinate and to share information and to increase communication and awareness on different tribal issues. The current topic of focus on this last call was tribal specific data to look at what's available out there and where the gaps exist and how to improve upon the system. So we are collaborating together on these calls. And the Tribal Support Unit is looking to improve the design for the website to make it more user-friendly by using topic boxes, so in the future, you will see more pictures and fewer words along on the screen so that the topic box will, for example, have policies, reports and publications or another topic box might have funding opportunities, announcements, or training and career development opportunities. So it should be easier for you to go and find what you need within these topic boxes. And lastly, I wanted to provide you with an update of some different resources that you might be interested in. Some of you may have seen the Knowing Tribal Health and Knowing State Public Health Primers that came out of ASTHO. You can find them at this website but they're also behind tab 10 in your binders, so there's a copy of those in there as well. And basically they're tips for creating successful partnerships between state health agencies and tribes and tribal organizations. So one is the Knowing Tribal Health and the other is Knowing State Public Health. Another good resource, Guide to Assessing Key OSTLTS Resources and Services. Actually, I take that back. I think this is the one that's actually in tab 10. The first one I listed is just the link is available, but the Guide to Assessing Key OSTLTS Resources and Services is in tab 10. And in that document, you'll find the different kinds of programs that OSTLTS offers for public assistance. So for example, there is information in there about public health law and different kinds of trainings, so take a look through there and see if there's some information that might be helpful for you. And then also the National Center for Health Statistics released an updated document on racial and ethnic disparities in July, so there is a link there for that as well, and there's American Indian/Alaska Native information that's included in this. That concludes my update. Thank you.

Metabolic Syndrome Discussion

Director Cathy Abramson: Thank you, Captain Shaw. Okay, at this time, we are going to have a presentation by Dr. Ursula Bauer on (Metallic syndrome discussion...what is it?) Oh, Metabolic. (I told you I'm no scientist.) She's the Director of the National Center for Chronic Disease Prevention and Health Promotion.

Dr. Ursula Bauer: Good morning everyone. Thank you for the opportunity to speak with you today at the summer TAC meeting, this happens to be my first time in Michigan and it's nice to meet with you all. You had requested a

discussion on Metabolic Syndrome and so that's what I look forward to delivering. And I hope that you'll ask questions. I wasn't sure exactly what about Metabolic Syndrome you were interested in hearing about so hopefully we can have the discussion and if I'm not able to answer your questions, I'll certainly be able to get you the information that you may need. So how common is Metabolic Syndrome. I'll just give you a quick run through of what we know in terms of the American Indian/Alaska Native population which is very little, and then I'll talk about some of the reasons why that is - our knowledge is imperfect around Metabolic Syndrome. I think that the point of this slide is that the key variabilities in terms of the prevalence of Metabolic Syndrome, this is a study that was done primarily of Alaska populations and the Navajo population, and you can see that depending on the region in Alaska there was quite a bit of variability in the prevalence and then in the southwestern U.S., in Navajo specifically, the prevalence was really quite high. And this compares to a prevalence of the U.S. non-Hispanic white population of men around 25% and women around 22%, so comparable to the western Alaska population, but we do see much higher prevalence, especially in the Navajo population.

So you might be asking what is Metabolic Syndrome, and it has a number of names including Syndrome X was an early favorite, Cardio Metabolic Syndrome. It's a cluster of risk factors that include obesity, insulin resistance, dyslipidemia or high cholesterol, and then raised blood pressure. And there has been thinking that maybe these are biologically related, that there's an underlying casual mechanism. It's not really clear and there's actually a fair good of debate about the utility of the whole concept of Metabolic Syndrome. But it has served the purpose of reminding us that risk factors for heart disease do cluster in individuals and if you find one risk factor like high blood pressure or obesity, it's a pretty good idea to look for other risk factors so that we can make sure that we're addressing all of these issues. It was - Metabolic Syndrome as a concept - was primarily developed in order to better predict heart disease outcomes in the future, so we can identify people at highest risk and can continue to prevent those, but it hasn't really worked well as an effective predictor of future events which is one of the reasons that we at CDC don't really focus on the concept of Metabolic Syndrome that much. This is a pretty complicated schematic that I'm not going to dwell on. It just gets at that cardio metabolic risk and the role of insulin resistance - it certainly plays a key underlying negative role in generating that cardiovascular risk associated with an increase in risk, and associated with the increase in blood pressure. Perhaps the results of obesity complicated by smoking and physical inactivity and so on. One of the weaknesses of Metabolic Syndrome is that it focuses on those four risk factors; obesity, insulin resistance, high cholesterol, blood pressure, but doesn't address what we know are very strong risk factors for heart disease including family history - probably the most important; smoking and age, sex and so on. So it's not as comprehensive a picture as we might like. To make matters worse there are a number of different,

competing definitions of Metabolic Syndrome. The World Health Organization was the first to propose a definition back in the late 1990's, and now that definition is not the most favorite. There are two sort of competing definitions which align fairly well but not exactly. So when we're comparing the prevalence of Metabolic Syndrome across different populations in different time periods, we really need to be sure that we're using the same definition. Otherwise, the prevalence rates are not comparable.

So a few things to think about in terms of Metabolic Syndrome. As I mentioned, it was developed as a construct really to focus on predicting cardiovascular risk; less so diabetes risk because diabetes is actually built into the definition of Metabolic Syndrome. Eighty percent of the people with diabetes will go on to die of cardiovascular disease, so that's a major risk factor for heart disease that we're very well aware of. As I mentioned, it does help us to focus on this clustering of risk factors but not—we at CDC and in my center really focus on pre-diabetes in terms of the intervention that we can deliver to try to improve health, and not everybody with Metabolic Syndrome has pre-diabetes and not everyone with pre-diabetes has Metabolic Syndrome. So it hasn't been a construct of a lot of utility for us. I do want to talk about how Metabolic Syndrome is treated because I think this is probably the key issue that the TAC is concerned with. Whether we're talking about Metabolic Syndrome or pre-diabetes or obesity, blood pressure, insulin resistance and so on, we do want to know what are the interventions that we can put in place to help our people stay healthy or improve their health. And across that canopy of diseases and conditions, the interventions are remarkably similar in terms of improving diet, increasing physical activity, of course, quitting smoking if the individual smokes; creating these permanent lifestyle changes that will help prevent a range of chronic diseases. Sometimes, as you know, those lifestyle changes are not sufficient or they're very hard to implement and in that case medications can be used to treat the individual condition, the blood pressure, the high cholesterol and so on.

I want to talk for my last few minutes about prevention of type II diabetes. At CDC, we're much more focused on the 89 million Americans who have pre-diabetes and trying to get them into proven programs that are delivered by the community to prevent those diseases, to prevent the progression to type II diabetes. We know that some 15 to 30 percent of people with prediabetes will progress to type II diabetes within five years and we know that we can maybe prevent that progression in most people with a simple 16 weeks with a total of a year of intervention, intensive initially, less intensive later on, delivered over a year that can be delivered by lay members in the community. Patients are referred by the clinicians and then there's reimbursement through health insurance and receiving Medicaid. And bringing all of those pieces together has been something that we've been working on at CDC for the last several years

and are making substantial progress in terms of getting the programs in place in communities and getting those third party payers on board so that we have a resource mechanism for the delivery. As I mentioned, in terms of Metabolic Syndrome, that diagnosis, if you will, of prediabetes is one of the components. It depends on the definition that you're using, but that is one way that we can identify people with prediabetes, and we're zeroing in on the impaired glucose and ascertaining that through a number of different tests. The National Diabetes Prevention Program has four components that we are aggressively working on now trying to increase that workforce across the country to deliver the program, assuring the payers that we are delivering that program with integrity and have the data to support the outcomes that the payers are looking for and that's the Recognition Program. So there's a process to go through for organizations that want to become deliverers of the program. And then we are trying to build uptake both of the diagnosing pre-diabetes in the clinical setting and referring people to that lifestyle intervention. And in this way we hope to build the foundation of programs across the country and begin to make a dent in this huge phenomenon – some have called it - which I know many of you are experiencing with your people with the epidemic of diabetes and that huge burden of pre-diabetes. And that concludes my presentation for Metabolic Syndrome. I'll be happy to start answering any questions.

Lt. Governor Jefferson Keel: I have a question. It has to do with pre-diabetes. When you say pre-diabetes, what does that really mean?

Dr. Ursula Bauer: Prediabetes refers to the insulin resistance, and that's diagnosed in one of three ways with three different tests and one of which is sufficient. So a fasting glucose test and the result is between 100 and 125 mg per deciliter. That would indicate impaired glucose, fasting glucose. If it's higher than 125, that's going to be diabetes as opposed to prediabetes. If it's lower than 100 it's not yet prediabetes. So it's in that middle range, 100 to 125, that leads to the diagnosis. A glucose tolerance test is another way and then the values are between 140 and 199 mg per deciliter. That's the glucose challenge test that occurs in the clinic. So that's another way to diagnose, and then hemoglobin A1C is the third, which would have a value of 5.7 to 6.4 on the hemoglobin A1C level. And we know that we have certainly dramatically improved our management of treatment of diabetes that we're seeing much better outcomes there and certainly the Special Diabetes Program for Indians has been a very good success. But we also know that we can prevent that - in many cases, prevent that diabetes from ever even happening if we can identify the individual with prediabetes and get them into that lifestyle intervention.

Lt. Governor Jefferson Keel: So once a person is diagnosed as diabetes, let's say whatever one of those tests show that they are diagnosed as a diabetic, can that ever be changed?

Dr. Ursula Bauer: So very good question. I would say in theory, yes, you could have a diagnosis of diabetes and you could dramatically transform your lifestyle losing quite a bit of weight, completely changing your diet, dramatically improving your physical activity and you could no longer have diabetes. And we certainly know that the rare cases where that has in fact occurred. Most people are not able to make that huge transformation that is required and they will have diabetes for the rest of their life. The diabetes can be managed very well and we've gotten even better at doing that, but the prediabetes, that's the warning sign. That's where we can say, it's looking like you're going down this road and you can stop that now without that major transformation that would be required. The weight loss in prediabetes is actually quite modest just 5 to 7 percent of body weight and the changes in nutrition and physical activity.

Chariman Herman Honanie: Herman Honanie. I have a dumb question. How are tribes or agencies across the nation dealing with this prediabetes diagnosis, or whatever you want to call it? I mean, how is that done and who's been successful at doing that?

Dr. Ursula Bauer: Very, very good question and one that we really struggle with. So we have the intervention and we have a number of organizations like the YUSA that have 3,000 brick and mortar venues across the country where they are trying to deliver this intervention. It has been very hard to get all of the planets aligned, if you will, to get the brick and mortar establishments and the trained workforce to deliver the interventions, get the clinicians to diagnose the prediabetes and get the health insurance to pay the community they deliver the interventions, if you will. So we have a number of successes in communities across the country and we are working hard to expand this nationwide and we do have some success stories working with some tribes although I'm not gonna be able to call those details to my mind. But really delivering this to the extent that's needed to reach those 89 million individuals has been a major challenge for us. The Special Diabetes Program for Indians does include that diagnosis of prediabetes as one of the things that they're striving for there but it's been hard to get clinicians across the country to incorporate that diagnosis and then do the referral and then have places to refer to. We do recognize that sort of the brick and mortar delivery where people have to come to a location to receive an intervention is very challenging and we have a number of studies underway, some of which are completed and have been very positive to look at virtual dissemination of the intervention, so whether that's through cable television, whether that's through telephone, whether that's through some kind of internet intervention, we are able, it looks like, to deliver the program virtually so that people don't have to travel and show up. So we're looking at how we can expand that kind of access as well.

Chairman Herman Honanie: I ask that question because just the other day, a couple of days ago, my son - my oldest son and I were – I don't know - we were in the truck driving someplace and he was just telling me, you know, dad, he said I think I'm going to be a diabetic, I know that I've been eating a lot of sugars and sweets and stuff like that. I said to him, you know, you ought to check your sugar, make a habit of it and see where you're at. So at what point do I know that I have diabetes? I didn't have an answer and I said I think anything over 150 is gonna be a sign that you're gonna be - you're diabetic, and even maybe higher than that. But my point is that it doesn't seem like I hear too much talk about pre-diabetes as well as an effort to really identify individuals on the reservation where I'm from. We hear the term constantly but I now ask what are we doing about it, and if we are doing anything, how successful have we been? I have to say I don't think that we've really made such progress because I'm not hearing from the CHR's and the IHS community medical staff that we are making a big impact on the prediabetes population or anything like that so that's the reason why I'm asking.

Dr. Ursula Bauer: I would agree with you that we are not making a big impact on the pre-diabetes population at this time, and our strategy, with very little funding, has been to try to build that infrastructure that's going to deliver the intervention. To your point, we have a lot more work to do to raise awareness about the condition. There seems to be a fair bit of awareness, especially in some American Indian/Alaska Native communities that "I'm destined to become diabetic." There's an expectation that "that's what happens when I get older," and so it will be critical for us and for tribal health services and for tribal communities to convey that this is actually within our control. We don't have to just as we age every year. It's not that we increase our risk of getting diabetes every year. That is something that we can take charge of with some modest changes. So getting that awareness out will be critical and we certainly look forward to partnering with you to figure out how to do that.

Ramona Antone-Nez: Thank you, Dr. Bauer and members of the TAC. Ramona Antone-Nez. Two things that I want to bring up. One is when you stated that 80% of the population that has diabetes will die of heart disease—if I heard you right. So the outcome of that is the mortality rate of the affects of diabetes, so we're looking at that spectrum. The other one is - the other point that I want to bring up is about the recognition program. You talked about the payers and you brought up data, that importance to have information. When you speak about data, is that a coordinated effort and does this model here have a database or dataset nationally or is that more regionally? I'm interested in about how the data is collected and stored and then recalled for public health reports for our local communities.

Dr. Ursula Bauer: Thank you for your question. So the purpose of the data with regard to the recognition program is to demonstrate that the organization that is implementing the intervention is delivering it to the community members in a way that is actually going to achieve the outcomes so that we are preventing the progression of type II diabetes. So what we ask of the individual program that is keeping recognition is that you report the number of people that you enroll in the program. We report whether those people participated in and completed the 16-week intensive intervention and then the monthly interventions thereafter to bringing to the close of the year. And then there's a baseline weight measurement and then there's a weight reported at each of the 16-week meetings and at the monthly sessions thereafter. And what those data then demonstrate is did the participants lose 5 to 7 percent of their body weight, was their blood pressure reduced. There are questions regarding diet and physical activity. Participants of part of the intervention are asked to keep track of their physical activity because we want to see, as part of the data that are reported, that people are actually accumulating minutes of physical activity and so on. So all of those data then demonstrate whether the intervention that's implemented according to design and then whether it achieves the health outcomes that we're all looking for. Once that's demonstrated and it takes a couple of weeks to do that, then the program is recognized. And then payers and clinicians are willing to refer patients there and pay for that service. We have a pending recognition status so that organizations that are going through that recognition process can accept referrals and be paid for their work with the expectation that they will get recognition when they've completed the recognition program.

Ramona Antone-Nez: Thank you, Dr. Bauer. So this program, this recognition, are you aware of this happening in Indian country or Alaska Native communities right now considering the public health system that we currently have? Thank you.

Dr. Ursula Bauer: So I will follow up on that and get back to you with an answer to that question.

Ramona Antone-Nez: One more question to that is, is this available online to get a better understanding about this particular program? I'm curious - my curiosity is how well can such a recognition program benefit Indian Country in terms of on the healthcare or the providers where they see the benefit to increase knowledge or increase the awareness on prediabetes? We want to get it at the primary and then work through secondary prevention and then, of course, the third part of it. So I'm just really curious about that. Is that available online to get a better understanding about how this program and this system works? Thank you.

Dr. Ursula Bauer: Sure. We can follow up and provide the link to the page on the CDC website that explains the recognition program. There's a lot of information there on the CDC website about that. I do want to clarify that when a physician or a clinical setting administers this program, it becomes very expensive and it's not cost effective to do. That's why the lay provider, if you will, delivering the program in the community is the way we think will really grow the program and the challenge is to develop that workforce and to get insurers more comfortable with paying those non-traditional providers, if you will. And we think that by delivering results, we'll increase the comfort level of both the clinician and the payer, hence the recognition program and the need to really focus on the intervention.

Lt. Governor Jefferson Keel: This is Jefferson Keel. What you just talked about was one of the topics I was gonna discuss and that is the expense. When you talk about trying to get this program—even testing, the general population, when a person goes to the clinic for any type of illness, particularly the direct service things in the Indian Health Service, most of the time they're not tested for these unless there's a specific reason for them to be tested, because of the expense, the lab work and all those things—unless they have some type of insurance. Some of those tribes across the country that are, I guess, more...have the ability to do some of these testings and extensive work then are more prepared. But then the other part of that is working with the other agencies to develop partnerships in terms of how we get these programs established in the communities. For instance, if you look at Medicaid, Medicaid doesn't pay for some of these tests. Medicare won't pay for some of these tests unless it's specifically asked for by the attending physician or primary care physician. So it's very difficult to assume that every patient that goes to a clinic is going to be tested or is going to have the benefit of some of these services. Some of the smaller clinics across the Indian Country simply don't have the staff or the facilities or the ability to do all this testing. Although it's wonderful to see and it is exciting that we're engaged in this, I think that the greater role for us is to look at how we develop these partnerships within HHS.

Dr. Ursula Bauer: I'll just make a couple of comments. One is that we would not recommend that everyone gets tested or that everyone receive the intervention. So if someone comes into a clinic and let's say they're older, they're in their 40's, certainly in their 50's, they're overweight or obese, they have high blood pressure, that's probably the time to start looking for pre-diabetes. If there's no pre-diabetes, we would not recommend the intervention but if there is, that's when we would hope that there's both a referral mechanism and someone could receive that individual in their community. You're absolutely right that a big key to scaling this program is to get Medicaid and Medicare onboard. We have two studies underway with CMS to demonstrate the efficacy - demonstrate the cost effectiveness of the intervention for those populations. Those are three-year

studies. I think we're about halfway through those and once they are convinced that yes this is improving health outcomes, improving quality of care and reducing costs, then we expect them to make a decision about actually covering the program.

Lt. Governor Jefferson Keel: Thank you. Just one last follow up and it has to do with you're talking about identifying those risk factors. I was thinking more along the youth. When you look at obesity in Indian country, that it's prevalent in many of our communities, many of those young people have those traits and so even those – even the ability to test many of those young people is limited.

Dr. Ursula Bauer: Thank you very much for that remark and that's critical. The emerging epidemic of type II diabetes in youth is a real tragedy and figuring out how to prevent that, how to diagnose that and get that managed is really critical. Thank you.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) On our reservation our tribe received a special diabetes for Indians grant. One of our first years in testing, we tested our K to 8th grades and in nine different schools on our reservation. One of them is a private school, all the rest are public, and I think it was like 38% are already at prediabetic stage. So, I think there needs to be more work at the school level for these children to start doing things. And there's also you know the kids aren't out moving around like they normally were. You'll see them at the house playing these different games all the time on TV. To me, I think CDC needs to figure out a way to get into those games to get kids more active.

Ramona Antone-Nez: Thank you very much Dr. Bauer and members of the TAC. I have...I want to go back to what Captain Shaw was talking about earlier when you talked about the coordination meeting between SAMHSA, CDC and IHS. I do not fully know what that coordination calls are, when they take place, who's on the call, etc. In light of this presentation, I would like to recommend that a discussion be brought forward to that coordination call in terms of how do we address prediabetes in tribal communities because, of course, in the areas we have IHS serving as many of our - as a primary provider, perhaps not always and then how does that—I mean maybe not primary but in the area where it's still federal facilities still remain and serve, and then it also would go into a coordination perhaps of how does this work in the 638 healthcare systems, the ones we had 638'd from the federal agencies, because really one way to address any of these chronic illnesses and this being one to prevent, that coordination effort really needs to take place. So I would like to make that recommendation and perhaps one of the ways is to get Dr. Bauer on the call after some sort of an agenda is formulated or something to that affect. Thank you.

CAPT April Shaw: Thank you for your comment. The calls that are currently taking place are with SAMHSA so I think they're more about substance abuse and mental health, but that doesn't mean that there can't be coordination calls started with IHS and CDC and anybody else that would be the appropriate person for issues around diabetes.

Ramona Antone-Nez: Thank you for that. This is Ramona Antone-Nez. I do want to say that in Indian Country exists the co-morbidities. It's not just about substance abuse when we're talking about SAMHSA. We've got to look at the whole picture in terms of many of our people who have prediabetes are diagnosed with—in this case type II—may be using substances such as alcohol, and then we get into the whole part about the process of progression to kidney dysfunctions and then we get into dialysis. So I understand that perhaps SAMHSA is just looking at it perhaps in one way for these coordination calls, but I would keep in mind and recommend that the co-morbidities do exist and we have to look at the person as a whole, as a community as a whole, not just one linear part of it, and that's where I would see the coordination—and would stand by that recommendation that that call start to talk and build upon an agenda where it's not just focused linearly. Thank you.

CAPT April Shaw: And depression is certainly—yes, it's found with diabetes. I'm actually a certified diabetes educator and so I really understand that and have worked in Indian Country with diabetes programs, so I really appreciate that comment and I mean, we can certainly propose that, you know, for the calls. Thank you.

Dr. Ursula Bauer: If I could comment as well, Ramona, I think you really made a critical point. The longer I work in chronic disease prevention and health promotion, the more I recognize that although we can do a lot to make the environment and the community more supportive of healthy choices and healthy behaviors, there is a motivational component to chronic disease prevention and health promotion. An individual does need to have self-efficacy to believe in their ability to take a positive step and they have to believe that there's a reason to do that. And mental health and behavioral health and substance abuse all get in the way of that self-efficacy and that belief in self and that hope for the future which can be so detrimental to chronic disease and to taking action. So absolutely see the comorbidity, the overlap, the inability to make real progress in some sense in chronic disease prevention and health promotion without also addressing the mental and behavioral issues. Those all piece together. Thank you.

Traditional Foods Discussion

Director Cathy Abramson: If there's no other questions, we'll go on with Dr. Bauer to talk about Traditional Foods discussion.

Dr. Ursula Bauer: Thank you very much, and I don't have slides for this presentation but it - was a good segue from Council Member Andy Joseph's comment about how do you get the kids more active and the discussion that we had about how do we improve people's ability to make healthy choices. And our Traditional Foods Program was one way that we tried to figure out how to do that and you'll notice that I'm speaking about that program in the past tense because it is a program that is wrapping up at the end of this year which is September. It will be completed. I had mentioned at the February TAC session that we were not putting out a new funding opportunity announcement for that program, and there were two reasons for that decision. One was that the program in the past had been a \$1.7 million program with \$1 million coming from the Indian Health Service, and this year the Indian Health Service did not provide us with that \$1 million, so we would've gone forward with a \$700,000 program which would have been a much smaller program. The second reason is that we were putting out a new funding opportunity announcement specifically for tribes that April mentioned was released in May. All of those applications came in in July and we're reviewing them now. And that is a \$14 million program and includes some component of the Traditional Foods Program. So we're very much looking forward to launching that new program and building on the lessons that we learned from the Traditional Foods Program. What we did learn from that program and from the 17 tribes in Alaska Native villages that implemented that program is something I think everybody knows around this table, right, that food is such a core component of culture and such a social activity that brings people together. And organizing around food, especially around traditional food, is really a way to think about health in the community, to bring the community together to build awareness about the relationship between social and emotional realm as healthy food and nourishing the body, and taking charge of our health through healthful nutrition, as well as a way of reconnecting or staying connected to our culture and our traditions and our history in the case of the Traditional Foods Program.

What this program tried to do is on an individual basis resurrect the traditional diet that nourished the people; bring those back or reemphasize them, and also the traditional ways of physical activity. Many of our traditional ways of eating involved a lot of physical activity, whether it was fishing or hunting or gathering or gardening and growing our food, so it's a fair bit of physical activity involved. So we really tried to incorporate the healthful nutrition, the traditional food, and the physical activity, the traditional forms of activity and really build a culture of health around that. We have a lot of success with this program but I think you can appreciate, from your own experience, how difficult it is to grow that kind of a promising program so that it is pervasive across the entire community and across all of Indian country, and we're hoping that we'll be able to scale some of those approaches with the new cooperative agreement. We're hopeful because we'll

have a lot more money with the new cooperative agreement, and we've structured that in a different way where we're including some leadership, some facilitation, convening and sharing of best practices through the tribal organizations component that I think will be very helpful in really disseminating some of the best practices that we know are going on within each tribe and village. So let me take a minute to describe the new scope of work and let me know what the timeframe is for announcing those awards. As April mentioned in her overview, we looked at the 12 IHS administrative areas and we looked at our \$14 million and we committed to funding one or up to two tribes directly in each of those 12 areas and up to two tribal organizations in each of those 12 areas to implement a program of work around nutrition, physical activity and avoiding commercial tobacco use, as well as a program of work strengthening the healthcare system. And this is where some awareness around prediabetes could be incorporated into that program of work. The tribes that are funded directly would implement activities in each of those four areas and the tribal organizations funded in each area would convene the tribes in that area, would provide tools and leadership and potentially small grants to ignite activities in one or more of these areas. Critically that tribal organization will be bringing tribes together to create opportunities to share best practices perhaps to build a little peer pressure across the tribes in the area to establish mentorship of relationships if that were helpful across tribes and to provide sort of that backbone to keep people focused on the activities, the lessons learned and how we push those out so that they're more widely put into use. We hope to invest some dollars in evaluation so that we can demonstrate the impact of the program and armed with those impacts, grow that program quite substantially over time so that we are reaching all tribes and villages and really investing dollars on that order of magnitude larger scale in an effort to relieve the burden out there. Let me stop here and see if there are questions on that funding opportunity or on the Traditional Foods Program.

Council Member Andy Joseph, Jr.: (Speaks in Native language.) My name is Badger. Anyway, I'm really glad to hear about this program. To me, it's really important. One of my elders told me that there's a cure for every sickness and there's an answer for every question but it's up to you to go out and find out what that is. As I've grown up around the traditional foods and the medicines, and the thing about it is at home there's not very many of the elders left that really know all of the different foods that are out there. And you're right, it does take a lot of physical strength to get some of these foods and our people follow the foods throughout the seasons. And you look at Washington State, the east side of the mountains from the Cascades clear into the buffalo country and Montana our people used to travel, so if it wasn't on horseback, it was on foot. And we would go clear down—part of my family is from up in Canada and they'd travel clear down to the Oregon Siletz Falls area to catch salmon or they'd go up to Kettle Falls and go up in the mountains. Right now, it's berry picking season and

salmon fishing season, so there'd be different towns throughout those areas and to me, some of our people don't really understand how to prepare the foods the way they used to do so that they'll keep throughout the years. And nowadays they have freezers. Back in our old days we never had a freezer. You had to dry and keep your foods a certain way. We never used the grease to you know cook our vegetables and anything like that. It was all natural. And to me, I would hope that there would be more resources for tribes to look at how many of these teachers might be left, the elders that could be given some kind of a stipend that wouldn't affect—a lot of times they can't really do a lot without affecting their retirement or whatever they're trying to make a living on. And to me, that bit of culture is gonna leave us really rapidly if we don't do something right away to obtain the knowledge that's out there. Like I said, I was fortunate to be raised around it. My daughter knows how to prepare just about any of them. But there aren't very many on my reservation that knows, but she knows.

Ramona Antone-Nez: Dr. Bauer and members of the tribe, this is Ramona Antone-Nez. In the Traditional Foods Program, it sounds like it's gonna be ending in September. Would you remind us about whether there were tribal communities involved? I mean who were the awardees and what were some of the lessons learned from their tenured funding opportunity. Thank you.

Dr. Ursula Bauer: Thank you. There were 17 awards in the most recent five-year cooperative agreement, and there were fewer awards—I want to say ten—in the previous cooperative agreement that was about three years. And a lot of the learning from the first cooperative agreement were incorporated into a second one. I think that there were a lot of learnings that actually—we just heard similar to what Council Member Andy Joseph, was saying. The need to really rediscover this knowledge or make sure that we obtain the knowledge from elders before it's gone. So, for example, one of the grantees, Cherokee of Oklahoma, actually had to go to their relatives back in North Carolina to get some of their traditional seeds so that they could grow their traditional foods in Oklahoma. That had been something that was lost with the relocation. One of the grantees in Alaska realized that hunting and dressing an animal is becoming a lost art, not just in Indian Country but across the country. And so in that program, one of the activities was to actually bring a deer into the third grade classroom so that as part of the school curriculum, the children would learn how to dress a deer and they would take that deer from the whole dressing to the preparation of the meat, to the preparation of the food, to the storage of the food. And similar activities with salmon which is a real food key there. So we do need to teach these skills if they're not going to be lost and we need to do that in kind of a proactive way, and we might not think about dressing a deer as something that fits into the school curriculum, but in fact, we need to do that if we want that knowledge to survive. In some areas, tribes have lost their traditional hunting and gathering rights, or maybe those rights are on the books but they're not well-

enforced or not well taken advantage of. So some of the activity is to work with the bureaucracy to try to make sure that we assert those rights and then we take advantage of those rights. So there was a wealth of experience and learning and really very different depending on the grantees and depending on their own context, and I'd be happy to send you a list of the 17.

Ramona Antone-Nez: Thank you, Dr. Bauer. This is Ramona. Real quick, I'm curious about the effectiveness of these programs. I do agree that it's important that knowledge and skill of traditional foods be revived and continue. In terms of incidence and prevalence rates, were we able to see through the programs that there was an improvement, or in this case a decrease, in the overall...one health disparity to an increase in wellness in terms of were there evidence or promising practices to show that there's a decrease in weight; therefore, increase our prevention to prediabetes? And we could talk about the chronics in terms of the risk factors for cancer, etc. But I'm just curious about how can we continue to capture the data that's needed to support these types of programs so that federally, we can continue to have them funded. Thank you.

Dr. Ursula Bauer: That is an excellent question and that is a contributing factor to why the program is not continuing. We can certainly demonstrate outcomes like increases in the amount of acreage that was farmed, pounds of vegetables that were harvested, numbers of people who took part in activities or who grew their own garden and so on, amount of foods...traditional foods that were consumed as part of the program. But those numbers actually are quite small and frankly the dollar investment was quite small. With 1.7 million, we don't expect to change the world. But it could be seen to me and to us as we looked at this program and thought about the huge burden of diseases out there and how we address it that this was the full answer. We saw that it needed to be incorporated into a fuller mix of activities, and frankly one of the activities that was missing is looking at the competing foods. So eating traditional foods sometimes is not going to undo or prevent the damage from eating the non-traditional foods most of the time. And the access to sugar-sweetened beverages and to the snacks and junk foods across Indian Country or across the U.S., across the world is unbelievably pervasive. And the foods taste good and they're cheap relatively speaking, so we have to look at the much larger culture within which a traditional foods program sits. And as we grow that connection to tradition and that connection to culture and that connection to healthy food, we have to be severing those ties to the prevailing food environment, if you will. So we see the future of the traditional foods approach as existing within a more comprehensive approach and for exactly the reason that was part of your question, how do we get the outcomes, how do we reach large numbers of people and how do we achieve health.

Council Member Andy Joseph, Jr.: You know, part of the problem, I would say, is access to our foods because a lot of our tribes were pushed onto reservations

where—we have to travel off the reservation to go get certain roots that we gather during the springtime, and you know to me, I think if we had more access—I could use my sister as an example. About seven years ago, she was diagnosed with stage four cancer and ever since she found out she had cancer and been going through all her treatments and everything, she spends most of her time gathering the traditional foods and eating those versus what's out there in the store. And she's I guess kind of like a miracle person because she's still alive. She's out picking berries right now and climbing around in the mountains, and that's a lot of work. Like a toothpick, just skin and bones but she's surviving. If more of our people would follow her example, I would say they'd probably be healthy like she is. I had a great, great grandmother who I clean her grave all the time. She lived to be 118 years old and you know that's the kind of health you know I want to see come back to our people. Right now, you know, I've outlived the average Native American in my tribe by two years. So to me I think it's something really important that the CDC should continue on looking at these ways to get that funding going because there is a big opportunity. I always say that that's my garden out there is in all the Umatilla territory that our tribes ran in and we need to have access to those areas so we can keep gathering our foods.

Director Cathy Abramson: Cathy Abramson. I think you guys all know that I've been a big supporter of the Traditional Foods Program and I continue, and I'm upset that decision was made awhile back that that was gonna discontinue. By the way, I did run them down last week. They were in the Bemidji area. All the grantees came and did their presentations on their best practices. It's very sad to see that go. I, like Andy, believe that if all our traditions—I mean every time we go somewhere for any type of—anything—our tribal leaders are saying bring back our culture and tradition. I would believe that there already is data out there on today's beverages and things like that, and there's no studies or research or data done on traditional foods. Again, I don't know how you do research or whatever. I do know this, and I said before I'm not a scientist, I guess, with us and our ancestors we've been scientists long ago. Our ancestors knew the medicines and just the way we lived. And we talked about it's not just about nutrition; it's not going and gathering food. I went picking blueberries. That's what you do at a certain time of the year. But out there when you're pickin them, there's St. Johns' Wort all over the place. St. Johns' Wort is for depression. So out there, there's medicines for cancer. So there's all of these things, so you're out there feeling really good, you're getting exercise, you're bending around, you're using your hands, you're picking berries, you're not smoking cigarettes because most of the time it's dry; you can't, you know, you're using your hands and you're picking your berries because you've gotta pick berries so you can get out of there so you can go swimming. Okay, so we had to fill our cans, so when we went as a family, so you had family time and then you had, again, more exercise and it was fun. We didn't drink pop or anything. We had water and good clean waters that we take for granted. So there's all of those things that

come into play and sometimes I think we don't get the big picture about what it is we're trying to talk about here. So, it's unfortunate. I would like to ask this the new awards come out and I would like to see a regular update from those individuals that oversee the programs, come to CDC and let us know about their programs, especially the Traditional Foods because to me, I'd like to use that 14 million and just improve the Traditional Foods program. You think of what we could do.

Chairman Herman Honanie: Herman Honanie. I'll try not to be too long. What I got out of this this morning and then just listening to everybody and some of the points that Ms. Nez here raised, we've got diabetes and pre-diabetes and everything else. It just reminds me of a group of individuals who have gotten together at home and who have started this several years ago about bringing back all the traditional practices and farming and planting and then food preparation and other things like raising chickens at home again, raising bees and producing honey. All of these kind of things. As kids, we used to go up to the rocks and you know get stung by the bees and everything else but to get the honey and bring it home was an adventure and all of these kind of things and so it just kind of reinforces what they're doing is really, really good but I hope that it continues to grow. And when I look around and hear all of us talking about what we used to do, what we don't have here, and you mentioned folks up in Alaska having to teach these kind of things, it just reminds me, too, that we started herding sheep – I was raised herding sheep and when my dad was around. You know, he would start with the sheep all the time for ceremonies and so forth and I'd be right there with him and so I learned how to do all of that. Then we switched over to cattle and we did the same thing. And then now, it's really a dying art. It's a dying practice, a tradition. Hardly anyone at home ever does herd sheep anymore so thus, hardly anybody knows how to butcher a sheep. And...but some of us will still do that for ceremonies and things like that. But I think the point I'm trying to make is that we just really have to step into that circle and continue ordering those efforts to do what had been done prior. And at least in my case, I'd like to think that many of the things that we have done and learned, our people have done in years past, are still doable. They're really doable with the economics, having jobs full-time and all of these kind of things is impacted as well, our livelihood and the way we practice our lives and tradition and so, like you mentioned, you just go to the grocery store and get everything you need. And then there's seasons involved and everything else. So it's a hard, hard way of life to do and cling to all of these traditions but you know it's not so bad when one is raised teaching and learning those practices. I remember when I was maybe about, I don't know, ten years old and we were planting and my grandfather came up to me and told me a couple of things about continuing the practice of farming. That's what we subsisted on, that's what got us here. And you (speaks in Native language)which is my Hopi name. He says,(speaks in Native language)[Hopi Name], you have to continue this. You have to keep practicing that so it won't go away so that you can live, so that you can feed your

family and your grandkids and so on and so forth and teach your grandkids, your sons, and everyone else. So I think we just have to realize that we're the ones responsible for a lot of the decline. We need to bring it back. We need to support it and we need to teach it and teach everyone around us how important it is and then hopefully it does impact our health in the most positive way. And I think it's really enough responsibility on our part. Ms. Nez talked about the consequences of a lot of things that we haven't done. We've missed the boat, so to speak, to prevent diabetes and everything else. A lot of things are happening throughout our reservations; substance abuse, alcohol, all of this kind of thing and that's why we're such a sick society. If we can do away with alcohol for starters, I think we could be on the road to being able to reduce substance abuse. I really think that and I really go out of my way—I have never been a substance abuser, I don't drink alcohol. So as a tribal leader, every opportunity I get, every time I'm out at a race or a gathering, I tell the kids, I tell the people, let's do away with alcohol, let's revolt against alcohol and substance abuse. I try to do that every time. I know some of my people don't like hearing it, don't like me saying that, but that's what I try to advocate and I think part of that is our tradition, is not to indulge in that. Thank you.

Director Cathy Abramson: Okay. Thank you very much. At this time we're going to hear wrap up from Romana Fetherolf before we go to lunch.

Romana Fetherolf: Good afternoon. I'm Romana Fetherolf and I will be giving the update or the highlights. During the TAC business portion of the meeting, Director Cathy Abramson had brought up that tribal members should contact their committee members and give them information that can be brought to the TAC meeting table. We discussed monthly phone calls, and Captain Shaw wanted to make sure that the current time and date for TAC calls worked for everyone. It's currently every other Monday at 2:00 p.m. Eastern Standard Time. If this does not work for you, just let Tribal Support know. The Issues and Recommendations document was discussed and Ms. Antone-Nez suggested adding a table of contents to the document. The document was voted on and approved. The minutes were also voted on and approved. The topic of funding was brought up as well as the topic of directly funding tribes versus sending money to the state. And then TAC members voted to have Councilman Chester Antone remain as chairperson and Lt. Governor Jefferson Keel voted in as vice-chair...starting tomorrow. We also had a presentation from Dr. Bauer on Metabolic Syndrome and Traditional Foods which brought up a lot of discussion from TAC members. Dr. Bauer and Tribal Support will work together to provide a link to the online information on the pre-diabetes recognition program so TAC members can see the information. And Ms. Antone-Nez had brought up a coordination meeting between the CDC, IHS, SAMHSA, and whoever else might be interested on how do we address pre-diabetes in tribal communities. There was also a suggestion from Director Abramson to get updates on what's the

progress with the grantees for these new grant awards being given out. So if I've forgotten anything, there was a lot of good discussion this morning, so if I've forgotten anything, please come see me during the break and I can add it to the minutes. Thank you.

Director Cathy Abramson: Thank you. I think Ramona said quite a bit that you might have not put down because I was commenting up here how she's a really good committee member. You might want to add. So we're all ready for lunch. Okay, we're going to give you till 1:10 for lunch. We're starting at 1:10. Okay. Thank you. Enjoy.

END. (LUNCH BREAK)

Smoking and Tobacco Use Panel

Director Cathy Abramson:Tobacco Use Panel. We have Brian King, Ph.D. He's Senior Scientific Advisor in the Office on Smoking and Health from CDC - shortened it. And Derek Bailey, Chairman Grand Traverse Band of Ottawa and Chippewa Indians and Director of the National Native Network for Cancer and Tobacco Prevention and Control Program. Welcome.

Dr. Brian King: Okay, well, thank you for having me. I'm grateful to be here. The last time I was at TAC was in 2012 and it was a very pleasant experience and got a lot of good follow up after that. So I'm really happy to be here today to talk to you about tobacco use and particularly the issue of E-cigarettes. It's a very emerging topic and so there's been a request to keep the slides to a minimum which I can appreciate and commend, at the same time. So I'll talk for about 5 to 10 minutes and then hopefully, we can open up the rest of the time for some really fruitful discussion about this emerging topic and can answer questions, and I'll give some more information on what the status of these products are and what are the interventions that we're using to address these products. So before I delve into the E-cigarettes, I'm just going to briefly talk about tobacco use in general, and of course, when I'm talking about this, this is commercial tobacco products so it's the non-sacred commercial products. And we'll start with the 50th anniversary Surgeon General's Report, which some of you may be aware of was released in January. This was the 50th anniversary report of the first Surgeon General's Report which was released in 1965 and that pictures our current acting Surgeon General, Boris Lushniak. And some of you may recall in the media where he claimed "enough is enough." And it was really a profound statement that addresses a lot of what we're doing in tobacco control and that we've been working on this issue for several decades and we have proven interventions that we know work, and it's more of just implementing those proven

interventions to get us to the end game intervention which is reducing tobacco use.

So in terms of background, these are two figures from that Surgeon General's Report. It outlines all of the diseases that we know are attributable to tobacco use and particularly smoking, as well as secondhand smoke exposure. So, all of the new items that were newly added in the 50th anniversary Surgeon General's Report are noted in the back. So the primary take home message is that really smoking damages nearly every part of your body, and the damage from smoking is not just limited to the user. We know that there's no safe level of secondhand smoke exposure. Even brief exposure has been known to have adverse health affects. And in terms of the death attributable to smoking, we know that in the United States about 480,000 deaths per year are estimated to be caused by active smokers, and it's about 50,000 for secondhand smoke. There's really a large burden of both disease and death and that's why we've shown in our Surgeon General's Report and elsewhere that tobacco use is the leading cause of preventable disease and death in this country.

So there's a lot of disparities, particularly with regard to cigarette smoking. Cigarette smoking and combustible tobacco use in general make up the greatest burden of death and disease from tobacco use and cigarette smoking is the most common type of tobacco use. Currently, there's about 18% of the U.S. population, adult population, who smoke and it's disparity by different groups, and this figure that I've included is by race/ethnicity. You can see there's this large area here on race/ethnicity. American Indians/Alaska Natives have higher rates of cigarette smoking, and the reason that you see that, the top line represents American Indian/ Alaska Natives in this figure and you can see that it jumps around a little bit and that's primarily the sample size but for the most part, it's been fairly stable at a comparable rate over time. And as you can see, that for most race/ethnicity, we haven't seen a lot of changes over time and plus underscoring the importance of these efforts to reduce tobacco use.

So in recent years, we've seen an emergence of new products. So cigarettes have always been the prominent tobacco product used but in recent years, particularly within the past five years we've seen an emergence of newly novel tobacco products, and one of the most prominent is E-cigarettes, and E-cigarettes are actually one type of a classic product we call Electronic Nicotine Delivery Systems. So E-cigarettes are just one of many and here's just a few examples in this diagram. They include things like e-hookahs, e-vape, e-cigars, pipes,, and hookah pens and currently 400 brands. Regardless of the product, they all operate...essentially...and other substances like flavoring. So they don't include tobacco as an active ingredient but the user inhales them and they include a liquid that usually contains nicotine. It's heated and then the user

inhales it and then release an aerosol which comes out of the mouth from the person as they use the product. So regardless of what type of product, they all operate under the same mechanism. Now, there's different ingredients and at the bottom of this...is the disposable varieties. These are the ones that resemble cigarettes. You use them and then after the liquid is done, you throw them out. So they're good for a day or two or some people will use them in a matter of - I don't know - an hour depending on how much they smoke.

The second generation is the ones in the middle, and these are closer to the e-hookahs. And they're a little bit larger. They consume a little bit more e-liquid and can be accessible and used several times. And the one on the far right is the tank systems, is what people call them, and these are rechargeable. And these are really becoming increasingly more popular among users, and one of the primary reasons is because they can be modified. So people can add flavors and any other ingredient that they find particularly appealing. There's also been reports that people are including other substances in the product as well like THC, which is the acronym for marijuana. So there's opportunity to modify these devices. As they get larger, there's more opportunity to have them modified to your liking.

Now, we've seen marked increases in the use of these products. They first came to the United States in 2007 and in terms of tobacco control the popularity increased more rapidly than we've seen for any other types of tobacco products including those previously mentioned. One of the primary reasons for that is advertising. And a lot of these products are manufactured by the tobacco industry which use traditional practices to make products appealing to people. And these are just a few examples. I like to include this because as you can see there's a lot of parallels. So in the 1940's and 50's you see Lucy - Lucille Ball and Ronald Regan advertising traditional products. And on the right here you have some more recent Jenny McCarthy, who you may know from The View....actively endorses Blu, which is a cigarette brand by the company Lorillard,..... as well as Stephen Dorff on the bottom right. I'm not quite clear on what Stephen Dorff is famous for. I'm sure it's something quite commendable. And so this is just an example of the advertising for these products. The increase in the advertising is mirrored by use and we've seen large upticks on the use among both adults and youth, particularly youths. CDC released a report last year showing that the prevalence doubled among U.S. middle and high school students in only one year. In 2012, there was 1.8 million U.S. middle and high school students who have tried tobacco products.....

And so there's a lot of debate about these products, particularly even in the public health community, and so I've compiled a brief overview of the potential

harm and benefits of these products. And as you can see, the harms outweigh the benefits, but it's important to understand these products and what the harms and benefits could be, particularly in the context combustible tobacco. When I say combustible, I'm talking about "burn products" like cigarettes and commercial products, cigars and anything else. So I'll start off with the potential harms and provide a few brief points on each that will hopefully help us move into the discussion of these products. For the first of the potential harms, and that's the lead to nicotine exposure among youth and pregnant women. So the products are currently not regulated although the Food and Drug Administration is now planning to regulate these tobacco products. So certainly it's kind of a free-for-all in terms of what these products include. But one of the factors that is in most of these products is nicotine. And, of course, we know that nicotine is the most addictive ingredient...that's the addictive agent in cigarette commercial products, but we also know that it's not completely without risk, particularly among adolescents and pregnant women. So nicotine can have adverse health affects on the developing adolescent brain and it can also have adverse affects on pregnant women, particularly with regard to fetal toxicity. So the nicotine exposure through these devices, particularly among these two populations, is a concern from a public health standpoint.

The second bullet is leads to initiation of combustible tobacco use among non-smokers or relapse among former smokers. So one thing that we're seeing in the data - population data, particularly among youth, is there's a lot of people who have never used traditional tobacco products like cigarettes that are using these e-cigarettes. And that's a concern for us because it could potentially lead as a gateway to use these combustible conventional products. And there's also concern with a relapse among people who have already quit that use e-cigarettes could potentially lead them to relapse back to using traditional tobacco products.

And the third item is delayed quitting among smokers. There is a lot of discussion back and forth about people using these products for cessation. And although anecdotally there are people who have used these for cessation in the population but the data is currently inconclusive if these products are effective. The studies are still emerging and particularly those that have found over time at the current point there's no conclusive evidence that these products are effective at all in cessation.

The fourth item is discourage smokers from using proven quit methods. By proven quit methods we mean products like nicotine replacement method like nicotine patches and medications that have been tested by the Food and Drug Administration which were shown to be effective. The FDA currently has seven approved medications for the purpose of cessation and e-cigarettes are not included on that list. So there's a concern that people will start to use these

unproven methods like e-cigarettes instead of these proven methods that have undergone rigorous scientific testing.

And the next item is expose non-users to secondhand aerosol, and all this means is it's similar to the secondhand smoke argument, and that these products are currently unregulated so what's ever included inside the product could then be aerosolized into the environment and potentially expose bystanders. So the inclusion of nicotine in these products is concerning for the same reasons that I noted before, and the children and pregnant women and non-users could be exposed to the aerosol from these products that could potentially include nicotine among other hazardous - potentially hazardous things.

And then the next one is renormalization of tobacco use. We've worked for several decades in this country to implement interventions that we know work to reduce tobacco use. An example of that is things like smoke-free lounge and policies that address the use of cigarettes in your areas that expose you to secondhand smoke. So the introduction of these e-cigarettes has added a wrinkle to that work in that it potentially renormalizes the use of these products. Because you are technically using a product, it looks exactly like the traditional cigarette. It's a vapor that looks similar to secondhand smoke inside you know indoor environments. For the most part, people can't discern between those products, so there's definitely opportunity for these products to complicate efforts to de-normalize tobacco use and even cessation.

And then the final note is regarding poisoning among users and non-users. CDC released a report earlier this year that addressed poisonings from these products and calls from poison control centers. And what that found was that in 2010 there was about—September of 2010-about one call per month of poison control calls. And then in 2014, the first couple of months, it's like all the way to over 200 calls per month and about half of those calls were for children under the age of five. So these products have the potential to poison people, non-users—users and non-users alike but particularly the children.

So those are the lists of the potential harms. But it's important to note that there's also potential benefits to these products and we recognize that, but the only way that there could be a potential benefit to these products is that there's complete substitution by establishment and no relapse. So that would be of all the current combustible tobaccos, is to switch to e-cigarettes completely and never go back. So that would be a net public health benefit to know that there's less carcinogens and toxins in e-cigarettes,so switching completely. But unfortunatly in the current data that's not what we're seeing. There's a large prevalence of dual use, and what dual use is is people continue to use both products. They're not quitting. So that's problematic for a variety of reasons.

And then finally the second benefit is that these products will assist in rapid transition for society with little or no use of combustible tobacco products. So in the event that these products help us to achieve our ending goal to completely eliminate combustible tobacco products then that would be...public health benefits.....But as I noted before, there's a lot of issues that complicate the ability to do so and if these products are allowed in indoor environments, then they can potentially complicate smoke free policies as well as other tobacco control efforts that we've implemented for several decades.....

So those are the overview of the harms and benefits of these products and since they're so new, the landscape of policies to address them is equally is new, but I'm going to include just a brief list of policy approaches that RB implemented at least at the local and state level, and in noting those it's important that what we're developing approaches to minimize the harms and we must also keep in mind the efforts to intensify efforts to address combustible tobacco use. That's still the primary driver of the burden of tobacco users in states. So when we implement policies to address e-cigarettes, it's important to keep them in context of our efforts to address combustible tobacco use

So in terms of one of the interventions that's been implemented most prominently is youth access to the products. Currently there's at the state level although the FDA has proposed a minimum age of sale standards at the national level. That has not gone into effect and it's still under public comments, but in the meantime there's about 30 states that have prohibited the sell of these products. In about 20 states it's still legal for a child under the age of 18 to walk into a mall kiosk or a convenient store and buy these products, and that's concerning. Particularly, we know that these products contain nicotine and potentially could serve as a gateway to other tobacco use. So one policy approach to spend adopted by an increasing number of The second is the inclusion of these products in a smoke-free policy and there's an increase in strides by states and localities to try to incorporate these e-cigarettes into our existing smoke-free policy so that these products cannot be used in any area where conventional tobacco products are prohibited. And that's for the reasons I outlined earlier for the aerosol and exposure to these products. And then finally an important note is that effective regulations for these products is key. And in 2009 the U.S. Food and Drug Administration received the authority to regulate tobacco products, and earlier this year they proposed regulating e-cigarettes. So the products aren't currently regulated and it could be awhile before those regulations. So in the meantime, it's important as public health practitioners and professionals to kind of understand the importance of being on the frontline so that we do the least harm as possible, and considering the harms of these products and the benefits and making sure that we implement common sense strategies to address these

products until we have more information on their ultimate long term impact on public health, particularly with tobacco use. So with that I have provided my contact information in the event that anyone would like to follow up on this or any other tobacco-related measure. I have the misfortune of having my initials in my last name so my email is baking@cdc.gov. It's very easy to remember, so I get a lot of interesting emails. I'll note that CDC Tobacco also has Facebook and Twitter. There's a lot of really great information. We're working on expanding our e-cigarette content as well working on simple resources that are easily digestible by the public help inform them about this topic. So with that, do we want to do questions after me or wait for the second presenter?

Counselor Derek Bailey: (Speaks in Native language.) Director Abramson, CDC, TAC, (speaks in Native language). I'm wearing two hats here today. I see here on my thing it says Chairman. Derek Bailey, I'm a past tribal chairman for the Grand Traverse Band of Ottawa and Chippewa Indians. I got reelected in May so my title is counselor but you're okay because I'm not on the clock. I just want to make that note. I also wanted, wearing the hat of the council member if I may bounce back, welcome to our property. I asked earlier if there was a welcome that was done from our tribal community and I heard that there wasn't. So if you may, let me go back a few hours and imagine that we're just kicking off the day. Welcome to our property. The Grand Traverse Band purchased the Grand Traverse Resort and Spa in March of 2003 and since taking ownership, we put about 18 million into the property, so we're very proud of this destination. It has housed other events, the National Congress of American Indians, the National Health Board with Lt. Governor Keel here, Council Member Joseph, and other tribal leaders that I've been able to rub elbows with, and to have you in our home community for the tribal leadership here. We welcome you to the staff of CDC, and the presenters. We hope that your time here, you feel at home. I see on the agenda tomorrow that you're gonna be visiting the Grand Traverse Band. Oh, Thursday. There's a lot going on this week here at this property. I don't know if you're aware but NIHB is in town, the Midwest Alliance of Sovereign Tribes and Health Services, and then we have a language camp going on, and then also this weekend is our annual traditional Jiingtamok Pow-wow. So it's a busy week for our tribe here. I have the opportunity to present on the National Native Network as program director. I had an interesting lunch, as I reflected upon my team and working with the National Native Network, which is administered by the Inner Tribal Council in Michigan. It changed my views as a tribal leader. Dr. King's presentation on electronic cigarettes and E-cigs and legislation and policies, definitely I've been impacted and so my presentation I'm gonna share and I hope that it helps and assists others in seeing that change can occur because it personally changed within me as a tribal leader and then coming back into the seat as a council member.

To start off, I want to recognize, too, a significant staff member for the National Native Network who's in the audience. It's Director Abramson's niece, Robin Clark. Please stand. She's part of the National Native Network and a citizen with the Sault Ste. Marie Tribe of Chippewa Indians. When we talk about a traditional concept of the work we're doing in Indian country targeting commercial tobacco cessation, think about messaging. Now for the Nishnabec, Midwest tribes, the Odawa, Ojibwe or Ojibwa, and Bodewadmi, here more commonly referenced as Chippewa, Ottawa and Potawatomi. We say Seymah or Seymo, as some pronounce it. And it's important because of all the partners of the National Network - National Native Network has a different type of message that goes into when working with tribal youth in our communities and also all the way to our elders, and we'll see it this weekend – we'll see it at our annual powwow, Jiingtamok as we say, and how that role of that medicine, our teaching, at least our direction comes into play as the ceremonies, education and daily life. Now daily life, what is that? If there is a disagreement in our teachings, you could take that, Dr. King, say he said something that perhaps didn't settle well. I could take that Seymah or get that to him in a means to say I'm coming in a good way from my heart and let's talk this through. If it's asking someone to take a role at a powwow and to answer (Speak in Native Language). What we see, though, is commercial tobacco is in place of our traditionally grown Seymah. We've seen cigarettes that are given or a pack or a whole carton to a host drum or a drum that's visiting. And you think about in that presentation, that delivery, what that really represents. To me, it represents almost giving someone cancer. Now, that's a hard statement to make but I really want to have that type of depth, that degree of understanding right there. Like giving cancer to someone. I've been at ceremonies where people, someone has walked on, traveled on, and I've seen commercial tobacco, cigarettes given out, youth smoking right with our elders. And I think about really what are we teaching. Now, there's elders in this room. I don't look to offend but at some point we have to start messaging what we're seeing in our communities. Is it okay for us to give that cigarette with all those additives this slide recognizes? Look at that last bullet point. Linked to high rates of disease, morbidity and mortality. And I bring that up as far as why my perception actually changed, and Chris, I'm going to go into some of our lunch discussion here, but we look at our communities as far as health risk, right? A lot of us have gaming facilities. At the Grand Traverse Band we have two, one out in Leelanau County, which we do the map of Michigan, it's the Pinky. If you haven't done that yet. But just down a few miles to the east is Turtle Creek Casino and Hotel. A smoking establishment. When I first became part of the National Native Network, I had the thoughts of, as a tribal leader, ADC board member, I'll tell you what, we can't touch the concept of smoke-free tribal casinos as a loss of gaining revenue. If you look at that last bullet point, the messaging that counters that is when our youth finish high school and they look to work. A lot of us come from rural reservations, tribal communities. Gaming facilities are the only means of employment because of limited resources, transportation. We

put them right into an environment, though, that has known health risks associated with them. When I first learned and started really identifying and saying, wait, I need to challenge my concept and perspective on—you know, as far as we've gotta have smoking in our tribal casinos. One thing I didn't recognize is the cost later in life. If you think about, and you know individuals - if you look at the CDC TIPS campaign, how many have heard of Nathan or had heard or watched Nathan Lane's story? He's walked on in the light fog. I mention his name in honor and respect because he was out at the forefront messaging as a non-smoker being in a smoking environment, and the impact on his life. And for a family that may be here or that may hear that I've spoken regarding this individual, he was at the forefront though and think, wait a minute, we need to really rethink what's happening in our tribal communities and what impact we're having on our next generation and our future leaders as well. You can go to the next one.

So the health burdens that we're talking about, if you look at commercial tobacco use in American and Alaska Native populations, the more prominent we come out with is heart disease, lung cancer, asthma, infant mortality. There's another individual that's a key spokesman for the CDC TIPS campaign, Michael George Patterson out of Alaska. Is anyone from Alaska here? I see that they're represented on the board. Well, this is another individual that's in a stage of his life, as he describes it, and he's very public about it but he's recognizing that his work needs to be done for what he suffers from. Now, if you look into—and Bemidji is targeted because we are in the Midwest region here today. When you look at the age-adjusted death rate due to malignant neoplasm per 100,000 population, if you look at Bemidji, you can see one region of Indian Country and the health risk, and I mention this cancer burden. In the first five years of the National Native Network, we focused on commercial tobacco cessation. We have now refunded for another five years to maintain that but also to incorporate a comprehensive cancer component. So I mentioned Kris Rhodes here earlier and the work she's doing. We are now into the next five years really making that not two silos but recognizing the overlap and how smoking or the use of commercial tobacco cessation leads to these increased health burdens or risks. If you look at Bemidji for the tribal leadership from the Bemidji region, we need to look at how it compares to the other IHS areas, and then for all of us in the room, compared to all United States - races within the United States. The American Indian Alaska Native commercial tobacco use—when you look at all this data and the collection methodologies, we recognize small population numbers, racial misclassification, regional, cultural and political variation. What does that all entail? We recognize that for data, sometimes we have the best intent in our tribal clinics and our health programs but if it's—as mentioned at lunchtime—high turnover, new systems coming into place, there is lost data or there's data that's there but it's not being obtained just because of perhaps staff turnover, a new system coming in, not adequately obtaining the prior data that was collected.

Now, this is important going forward. The Grand Traverse Band, we're a checkerboard tribe- you've heard that phrase, our land ownings, aren't all together. There are locations throughout our six county service area. We had to put in our tribal resources to gather the data, if it's messaging about screenings, but getting out and being mobile—if that's the word I'm looking for—into those outlying areas. And that's also an important part, our tribal health clinic, part of our service area is an hour and a half drive. That's a lot to ask of elders in today's day and age with gas prices where they're at as well. So we have to take it upon ourselves as tribes, too, to get out into those areas. Also our urban settings. We know that there's high native populations within our urban settings, and it's getting to those locations, too, to obtain the data that's needed.

Funding. Scientifically rigorous and culturally appropriate. I can't emphasize enough the culturally appropriate. When we look at the American Indian adult tobacco survey, now this was conducted and needs to be updated, but in person interviews were conducted by community members. In it was included traditional tobacco use and cultural cues. Each of the tribes administered it, so it was tribal specific data. And here's the key thing, too. Tribally owned data. Ownership. Cause I'll tell you what, I don't know if you've heard it but I've heard it for quite a few years, our elders, they're tired of being surveyed. Even within our own tribal government sending out surveys, they're like we've been surveyed enough. But I think the key here is if you can get the ownership of why that data collection is necessary, and if you look at that last bullet point, approve services and surveillance, going back to changing perspective, if you have a council that is looking at not touching the smoke-free tribal facility, one way to message is if you look at though by putting an individual in an unhealthy environment, what are the health risks, what is the long health risks associated with that environment that's gonna come back upon the government and the budget for healthcare services. Sometimes messaging isn't as upfront as would be for us. I'm MSW so I say, heyDerek, don't you want life to be better, have people you know be able to live longer? Yeah. But some individuals, they need to see numbers. They've got to be correlated in a means of if we don't do this move here, we're gonna pay that and/or more in meeting the healthcare needs as our tribal citizens grow older from working in a smoking environment. I think that's key. And I'm sitting here as a council member telling you I have experienced both sides of that from a heartfelt message to someone needing hard numbers and making a decision on that. Some of the data that was collected in the Bemidji region—again, I apologize for those outside of it but we are in our home area here. If you can see the data that was collected here for never smoking, former and current smoker, these are rates that are also—if you look at throughout other parts of Indian Country, if it's Plains, Southwest, and I mentioned Alaska, too. What's interesting there is that we found out that our emphasis on traditional teachings on our website, if you've got your smart phones, keepitsacred.org. I'll say it again, keepitsacred.org. A lot of information there. But in our work we recognize

that—and I didn't know this—my wife is Alaska Native Ubic so I should have known this, but they don't have the traditional teachings for tobacco that a lot of the tribes do, what they say in the lower 48 or, you know, throughout our regions here. But at the same time they utilize—and I wish someone was from here because I forgot what they call it but they have a tobacco farm and you see it within their youth use it, too. And I had a niece staying with us. She was in 8th grade at the time and here I was doing this kind of work and she came to visit and my wife said, yeah, she needs to chew. So for back home she did. I was like, wait, we've got a minor here, we've got a youth, I'm doing this kind of work. But that was a culturally appropriate from their trinity, their village that youth incorporated in their youth. I'm not saying it's right or wrong, I'm just saying that we have to be very respectful of different regions throughout Indian country in the messaging that we're doing to lower the use and recognizing the health risks associated with high use. That's really - if you look at different regions you can see that high use is very prevalent and sometimes even by tribe, it's amazing the numbers associated with use from youth to elders.

"Miigwetch" means thank you in this area here. And one of the information, talk about media resources and what messaging goes out, specific to Michigan, as this banner states, nearly 14,500 people die every year from commercial tobacco use in Michigan. Tobacco companies target youth to replace them. That's key. How many of our tribal convenient stores, our C stores, our gas stations that they sell tobacco products, how many of them are at eye-level? Or candy cigarettes are at eye-level? Are we doing our efforts within our tribal communities? So it's not an ease of association or it's not an ease of acceptance. Are we really promoting the educational piece that we need and communicating what the health risks are? But, and if I can stress this again, but—the creator's gift was to us as Indian people for that sacred medicinal property of Seymah or whatever you say, how you say it in your language, is that what we're emphasizing, are we growing that? In our ways the men grow that. They grow that Seymah. Are we accepting that commercial tobacco in our ceremonies? Are we saying, wait a minute, no, we want to make a movement - a grassroots movement and say we grow our own in our traditional way, and then we gift it in that way. Those are messages, those are questions I can't answer for everyone, but we can all do our part in that bigger picture. So miigwetch - thank you. I appreciate this opportunity to present on behalf of the National Native Network to the leadership around the table and those in the audience. Miigwetch.

Director Cathy Abramson: Thank you. At this time we'll take questions.

Chairman Herman Honanie: Hi, good afternoon. (Speaks in Native language.) Thank you for being here to remind us and speak to us about the dangers of commercial cigarettes. I'm Herman Honanie, Chairman of the Hopi Tribe, and I really appreciate what you have to say from a cultural perspective in

terms of how much I've seen the presence of commercial tobacco in ceremonies. And I'd like to say that gradually, I'm seeing less of that now today because of our tribe had an educational tobacco cessation educator up until recently, but he was very involved in bringing attention to the dangers of smoking commercial cigarettes and tobacco, and as a result, I think a lot of men, especially men, have taken note and especially in the ceremonial settings. And I do agree with you that when prior to that education men who would bring cartons and packs of cigarettes into our ceremonial chambers, and many times, I heard our elders say in Hopi just what you said. You've brought sickness again. And they would go on to even say specifically you've brought what the white man calls cancer into our building again. And just little remarks like that have caught on, I believe, to educate our people that maybe there is truth to that statement and their observations of it. And so like I said, I think I'm seeing less and less of that because our ceremonial changes may be - might be a third of this area of this room here, and when natural tobacco and commercial tobacco was smoked, we were in a fog, a cloud of smoke within that and it seems to have really cleared up, if you will, much much so. And I think that as tribal leaders, I think when we're looking at the health side and the dangers of commercial cigarettes, I think we owe our people that message that we have to advocate the less and less use of this commercial tobacco, that we should promote our own natural tobacco. That's what we utilize anyway and so along came commercial tobacco. It just overcame the presence of natural tobacco. I'm a member of the Tobacco Clan in my community, in my tribe, so it's my obligation to provide the natural tobacco for ceremonies. People traditionally would come to my clan and ask for natural tobacco and we were always responsible for always having on hand the tobacco and we would give to the people who were asking, and especially sponsoring the ceremonies. But now it seems like everybody wants to have that role and so that's a cultural thing but that's our issue but I think yourself talking about the dangers of commercial tobacco is a really effective way of addressing that and I just really want to applaud you and thank you for saying that and thank you for bringing that attention to our – matter to our attention. Thank you.

Director Cathy Abramson: You want to go Lt. Jefferson Keel.

Lt. Governor Jefferson Keel: Thank you. My name is Jefferson Keel and I apologize, I missed – I may have missed part of the presentation but my question is the difference between traditional tobacco and commercial tobacco—is traditional tobacco less likely to cause cancer? I mean is there less tar and nicotine and all those things in the traditional form of tobacco?

Dr. Brian King: The short answer is yes. So there's about 7,000 chemicals and toxins in tobacco smoke including about 70 that we know cause cancer. So a lot of those ingredients are put in there during the manufacturing process by the tobacco company to make products more appealing and sustain addiction in

terms of the products. So a lot of those artificial ingredients and chemicals are not in traditional products. And yields a lower risk of chronic tobacco use.

Lt. Governor Jefferson Keel: Okay, and the follow up to that is someone mentioned about regulation of the FDA regulating this. You know, there has to be a crossover there when we talk about the FDA being a federal—it is a federal agency and it does have a responsibility to consumers to either report its shortcomings or findings. But right now there's the marijuana legal issues both in Colorado and Washington State. FDA doesn't have any regulation on that. It's not regulated yet. So in terms of how we develop a strategy in Indian Country to counteract, not just tobacco but the e-cigarettes and all those things, the e-cigarettes from what I understand, are just as—they're just as dangerous to your health. They create just as much of a health hazard as cigarettes. Is that correct?

Dr. Brian King: That, I wouldn't agree with. So they're not necessarily just as dangerous in terms of ingredients but it's more of an aerosol but(inaudible)... significantly less toxins.....

Lt. Governor Jefferson Keel: Is that true of the aerosol?

Dr. Brian King: They're still investigating. In some of the aerosol studies, they've found things like metals and alkynes and Formaldehyde and a lot of it comes down to products aren't regulated so there's all sorts of things. But the studies are still coming out. The current science, they're less harmful but not not harmful at all.

Lt. Governor Jefferson Keel: Well, I think that is the problem we have across the country is that people are confused. They think, well, if you use these e-cigarettes, and they're less dangerous, they don't cause as many problems. So the marketing strategy there, it's easy to catch on. How do we get past that, you know, particularly in Indian Country, and I understand the traditional use of tobacco in many cultures and I'm not saying it's right or wrong, I'm not trying to be judgmental, I'm just saying how do we get to the point where Indian Country can say it's safe to use these things when the studies aren't complete.

Counselor Derek Bailey: I'll speak to myself as well in my response. As sovereign tribal nations, regardless of FDA regulations, it's upon—it'd be dependent upon ourselves to—in the activist legislation policies, if smoking, if use of commercial tobacco use, if we know the prevalence, the rates, the statistics just in one region isn't alarming enough, we need to really step back and see what are we doing. What are we doing around this table? I've sat with you Lt. Governor, on different panels and committees, so I'm speaking to myself even looking past my work with the LDC. You know, what we do—are we just

going to go through the motions or are we gonna say, wait a minute, and we can, we are from sovereign tribal nations. You know, to hear someone from the tobacco clan speak, that was powerful to me as raising my awareness and understanding. I'm not at all responding in a negative way, but I know that we have to be more at the forefront. One of the questions I have been asked in a radio interview was can e-cigarettes be used in your ceremonies? You know and it's like we have to start talking about what is contained, as Dr. King mentioned, you know, studies really aren't that concrete yet on e-cigarettes, but if people are already trying to look around and say, hey, how can we incorporate in that liquid, you know, there's tobacco so does that make that e-cigarette—can you use that in a sacred ceremonial way? There's a spark, there's a fire, you know, but I think I use that example of that question because we have to start saying within our communities are we giving that you know form of tobacco that's got all the ingredients that Dr. King listed? Not all, because there's 7,000 of them. But just think, 7,000 ingredients, powerful ingredients within that; or are we gonna take a stand and say, hey, let's lead the way. The tobacco plant, the Seymah plant from the chairman's nation, we're going to grow it. And we're not gonna accept commercial tobacco. We want that traditional you know used in our communities. That's what's gonna do it, regardless of waiting on regulations from the United States government.

Ramona Antone-Nez: Good afternoon. Thank you, members of the TAC and presenters. I'm Ramona Antone-Nez and I'm from Navajo Nation. A couple of items that I'd like to ask questions about. One is e-cigarettes in terms of you mentioned it as a gateway to conventional cigarettes. Is e-cig also considered a gateway to other drugs as before our conventional cigarettes have been categorized or identified as a gateway to other drugs? Is that a possibility? That's one question. The other question is about chew tobacco. I appreciate that you had brought that up because in Navajo we had conducted the BRFSS which is the Behavioral Risk Factor Surveillance System in one of the agencies that we have five of them. In this particular finding, we found that there was a lower prevalence of commercial tobacco and the higher prevalence was tobacco - chew tobacco use. We found that to be very interesting because perhaps there's a misperception that maybe it's less harmful because there's not that effects of secondhand smoke. My question is, are there prevention strategies that CDC is currently using targeting chew tobacco? The third one is about cessation programs. Is there one that CDC has or to be found effective? And if so, what is the success rate of that cessation program in terms of Indian Country? Thank you.

Dr. Brian King: Okay, so I can address all three and by all means interrupt if I'm not addressing them all. So the first one in terms of the gateway. In direct response to your question, there is potential, but we don't have the data on that. And right now the studies that we have are cross sectional, which means that we

take information at one point in time, so we don't get at something the scientists—the stuffy word is temporality, and what happens over time and what came first. So we don't know if the cigarettes came first or e-cigarettes came first. So right now the product is so new that the science is still evolving but there's a lot of studies currently in the works that would be able to assess people over time to see did they start conventional cigarettes first and then transitioned to e-cigarettes, or was it the reverse or when did it happen. Then also to ask people about why did you use it, when did you use it, what types did you use. So we've gotten to a point now where enough people are using the product long enough so that we can get at that question. So there's definitely potential for the product in terms of a gateway, particularly among youth. And one intriguing finding that that study we did in U.S. middle high school students was that there was a large percentage among the middle school students that use the e-cigarettes, 20 percent, one in five, have never used conventional cigarettes. And that's concerning to us because these people have never had any susceptibility or exposure to these conventional products and now they're using a product that is very similar in terms of use. So there's certainly potential for that gateway, and hopefully over the next few years we'll have some new information. In regards to your second question about chewing tobacco, and when you said harm perception, you really hit the nail right on the head. This is a very topical issue right now in tobacco control and the idea of reduced harm from the use of non-combustible products and e-cigarettes. And so there is an idea, a thought among some in the public health community and elsewhere that non-combustible products are less harmful and thus an effective way to promote cessation. And smokeless products like chew, dip, snuff and snus as well as things like e-cigarettes are frequently included in that. And the response to that is that we know that all forms of tobacco use are dangerous particularly commercial ones. So there may be less harm with some of these products but with smokeless tobacco we usually start thinking about risk. We know that using tobacco products causes several diseases particularly oral cancer. So there is a body of scientific work showing that it's dangerous to use these products. So it may not be a dramatic decrease of the use of combustible tobacco but there's still an added risk in that the commercial products that we know. In terms of the cessation program question, a lot of the evidence addresses all forms of tobacco use. So most of these products include nicotine and a lot of the times they're quite similar in the ways to quit smoking and get off of tobacco use. So nicotine...therapy like the patch or the gum are still effective methods to reduce and quit all forms of tobacco irrespective of whether you're smoking it or whether you chew. Similarly, there's a lot of, you know, evidence based strategies at the population level that have been used to quit these products. So aside from medications, you go to counseling, even brief counseling but there's one that has really added value and that's mass media campaigns. And we touched on that in your questions and we know that mass media campaigns, such as "Tips from a Former Smokers" the CDC ran, can deliver an

effective message. A lot of that is through education. People may not know the risks of smokeless tobacco and so it's getting the message across. And then also another issue is the tobacco-free policies. And there's an increase across the country to include all forms of tobacco use including smokeless tobacco. And so particularly in healthcare facilities there's large bans on all forms of commercial tobacco use whether it's smoke, like a cigarette or a chewing product is not allowed. And that gets us to this whole theme of motivation(?) where people aren't using these products and to shift society from a point where we see all forms of tobacco use including..... So the short answer to your question, really that we have proven interventions that we know work or implementing this broad landscape of tobacco products, not just cigarettes because the landscape is very driven by the year-to-year shift and people using other forms of tobacco besides cigarettes. It's important to keep those in context If I didn't answer, let me know.

Ramona Antone-Nez: Thank you. I asked a question about the success rate on cessation and perhaps your response is about the proven use of patch and the gum. So that helps. So just to help with my thought processes, members of the TAC, is in Navajo, we have a healthcare system, public health system that includes both federal IHS facilities and also the 638 facility. And I just am curious about looking into how this effect is back home; not just the rates, but whether we have effective programs and access to the effective methods to cessation in terms of the patch and gums. I'm just curious about that - how that looks in your neck of the country and as well as mine. So just that curiosity is now there. Just want to say thank you, and I do have many of the issues that were brought up in terms of ceremonial uses and the social gatherings and the powwow's, etc., in the form of gift, and we share that as well. Thank you.

Director Cathy Abramson: I just wanted to bring one thing up. I was gonna announce it towards the end, but I decided to bring it up now. Keeping in mind the discussion about smoking traditional tobacco versus commercial tobacco, there is a public health - tribal public health law training that is sponsored by NIHB on Thursday which is free to everyone. I know that TAC members will be going on their site visit, but anybody else who's interested, we'll be doing the training in the end, we'll be discussing how to draft public health law and working with participants to workshop-specific language that they can take back to their own communities. And tobacco would be perfect, you know, like the perfect topic, so I know in our community, so you might want to keep that in mind when you go to this training keep that in mind. So I just wanted to bring that up.

CAPT April Shaw: I had a question for Dr. King. So when you were talking about the secondhand smoke and you mentioned e-cigarette, there's also the secondhand smoke; how do the potential harmful effects, how do they compare between the e-cigarette and then the commercial tobacco?

Dr. Brian King: So the response to that is similar to the active use of the products. So right now studies that are out, it's far less. It's not 7,000 toxins, it's 70 carcinogens. There's been 100 studies and some have found a diverse array of different ingredients..But in that conversation I think it's important to think that our standard is really what's in the air. And so even though there is less risk fromaerosol....they're still not without any risk at all, particularly there.So in all the debates and conversations.... And so the discussion isn't necessarily comparing the two so much as we really want clean air standards and so many of our efforts to address these products in closed environments is really to keep clean air as opposed to one is safer than the other. But there's still emerging science on the topic but the aerosol-produced product is not without any risk at all.

CAPT April Shaw: Did anyone else have any questions because I have a few, but your questions need to come before mine. Anyone else?

Chairman Robert Flying Hawk: Thank you. Just one question. I thought I heard you say - oh I'm - Robert Flying Hawk, the chairman of the Yankton tribe -there was a study or survey done on the native tobaccos or use? Is that what I heard you say or did I misunderstand that?

Counselor Derek Bailey: The American Indian Adult Tobacco Survey- it covered the use, prevalence, history, association with smoking but it also had parts in there for—others have talked about with the traditional use, ceremonial use, daily - incorporation on our daily lives. So that information, and it goes back to—because again it was tribal administered and the ownership of that data recognizing that you're not being surveyed by an entity somewhere, who knows where, but it came from within. The leadership wanted to see that within their tribal community was key to And I misspoke earlier. I wondered why Dr. King kicked me under the table. I said there was tobacco in that liquid. I meant nicotine, and that was that association there.

Chairman Herman Honanie: Herman Honanie. I just have a question with regard to some of the commercial cigarettes produced. I assumed or I'm being told that by companies that have—I don't know whether they're Indian owned or whatever but there's a couple of companies that put out cigarettes, are they any less harmful or contain less of those toxic ingredients in their production of the cigarettes?

Dr. Brian King: I'm not aware of any studies. I know that there have been some advertisements in particular saying that these products are less harmful but I'm

not aware of any studies that specifically said that. I'd be surprised if they were without any type of risk at all but it's something like that. It's important to remember that any time you have a manufactured product that you want people to purchase, it's in your best interest to make it particularly appealing to them and that's why a lot of manufacturers whether they are big (inaudible word) or smaller company, you know, include (inaudible word) to make products enticing and easier to use to build up on clientele. But in terms of specific studies addressing that, I'm not aware of that.

Chairman Herman Honanie: I ask that simply because about a year ago, we had a couple of representatives that were on the reservation going from business to business advocating that particular brand. Gosh, I can't even think of the name of the brand, but they were saying that it's not so much toxic-free but very, very a lot better than the comparable commercial cigarettes that everybody else produces.

Dr. Brian King: Spirit maybe? American Spirit?

Chairman Herman Honanie: Yes, I think that's one of them.

Dr. Brian King: Yes, and that's probably the most prolific advertisement for that. I'm not aware of any studies..

Yes, yes, certainly. So Ursula, she noted that our lab investigated that and I'm not aware of the findings of that so we can certainly look into that as well. Another issue that she noted was the filtered products, and that's also something interesting to note because the filters have been modified over the years and they've located them in spots where you put the fingers that are—you actually have to inhale harder, and so they've manufactured to the point where the filter is in the exact location where your fingers are so that also makes it more enticing to the user and they have to inhale harder to actually get a kick from the product. So there's a lot of manufacturing to these products that are along the lines of what I noted before these products are more enticing to the user. And that's gonna include anything from the filter all the way to flavoring, particularly menthol.

Chairman Robert Flying Hawk: So, again, related to Chairman Honanie's question of the studies. If there was a request made to have a study done of native cigarettes, our area in the Plains is called kinnikinnick and I'm not sure of the other areas but—and then the use of it was ceremonial with a pipe in a ceremony in moderation, I guess, was a word or in the use of it. But no studies have been done of tobaccos or ceremonial tobacco that was used. And I'm not sure if kinnikinnick what we use in Plains could be considered tobacco. It's not a

leaf or anything like that but no studies, anything like that have been done, and could one be done?

Dr. Ursula Bauer: I'll make a couple of points on this issue. Tribally-produced commercial cigarettes versus traditional commercial cigarettes and then the traditional tobacco versus the commercial manufactured tobacco. And one is—so the first point is, regardless of the substance, if you burn something and inhale that burned smoke into your body 10, 15 times over the course of a smoke, 15, 20 times a day, you're going to do a lot of damage to your body, regardless of what that substance is that you're burning because the products of combustion are inherently harmful to the body. When you manufacture that substance commercially and you put a filter on it, it makes it very easy for you to inhale that product very deeply into your lungs, you're gonna do a whole lot more damage and that's one of the differences between traditional tobacco and how you use it ceremonially and commercial tobacco and how you're smoking that to the filter deep into your lungs versus smoking through a pipe, keeping that smoke largely in your mouth and exhaling it in your ceremony. But as soon as you take—and then there's the difference of the ingredients in tobacco, the tobacco plant with nicotine versus some of the ingredients in traditional tobacco which may include some of the nicotiny plants but may include a lot of other natural plants as well, so the nicotine levels are very different. Maybe non-existent in the traditional tobacco. In terms of a product like American Spirit cigarettes, there are lots of additives in that manufacturing product and they are trade secrets and they are a secret sauce from Marlboro to Camel to American Spirit, but they all contain nicotine, they all contain tobacco, they all contain a lot of these products that make it easier and smoother for you to smoke, and they all burn the smoke into a filter and into your lungs. So the health difference between a tribally manufactured commercial cigarette and a Phillip Morris commercial cigarette is not going to be detectable, likely, in any kind of study.

Counselor Derek Bailey: I think the key words that come down to me is manufactured and homegrown, and if it's any type of manufactured—you have the statements that Ursula just mentioned and Dr. King went through that are homegrown. I go back to that's a gift from the creator. However you, in your own language, traditional language, visionist language, how you speak to that—I want to be very clear here, too, Director Abramson, that I am in no way advocating for the non-use of Seymah in our ceremonies because that was given to us in those teachings. I carry a pipe myself and we're taught—when you talk about inhaling this. Those are English words to describe our ceremonial use of Seymah, and I don't want to be putting a light but I'm saying we can't use that in our ways. In fact, I advocate strongly for that because that's what the creator gave us as the Nishnabic people to help with our spirituality and our ways and our beliefs and to draw from that and know what we do with that and why that goes

on. And we know that in this room. So I don't want to get to the point where I'm saying we be free of that in our ceremonies and that's why the messaging within Indian Country is different for the National Native Network as it is to others within the National Network. We can't lose sight because that's who we are-(speaks in Native language)- who we are, as the ways and the teachings that our ancestors held. As ancestors today of future generations, we've got to keep that in mind, too. I appreciate those comments but I just had to say that. I couldn't not respond to that.

dDirector Cathy Abramson: Oh, I didn't think—I wasn't thinking in that way. We just have to sit down and have a long discussion, that's all. My mind is going ten million miles an hour, too. Any other – okay, Andy?

Council Member Andy Joseph, Jr.: I guess myself, I can't stand smoke. It's hard to be around it when we know that there's all these ingredients in the different tobacco products. To me, that little warning on the package isn't good enough and I think our government should do something more severe about it. At home, we do have our traditional type of tobacco and it isn't anything like what is grown back this way. We go in our mountains and pick different plants that are out there that we use in our pipes. I was given a pipe in one of our sacred ceremonies that we have in the wintertime and when I use it, I use it for prayer and for healing, asking for things to go good for our people. But seeing children buying or getting access to cigarettes is something that I think the government really needs to get a handle on. I know our tribe benefits from tobacco taxes and things like that, and it just drives me nuts because I know it's probably causing a lot of the deaths that happen throughout our area. And to me, it just don't seem right - that all those ingredients should be outlawed. At least if it was natural and people took part in it, I think you'd probably cut down on maybe half the people that it kills. But they keep allowing those big companies to put all them ingredients in there. We're just gonna be talking about it again next year and the year after.

Director Cathy Abramson: For the committee's interest, a Great Lakes Epi Center study recently published in the Journal of Preventative Health featured permission to access the casino patron database to investigate patron perceptions of smoke-free preferences when visiting a casino. Results and patrons prefer a smoke-free environment and would visit more frequently. So if you want more information, call Kristin Hill at the Great Lakes Tribal Epi Center. She's right over there in the front row. Wave Kristin.

Chairman Herman Honanie: I just want to share something. I was down in Prescott, Arizona a week ago and we stopped up at this little mall and right across from the Yellow Pie Tribal Smoke Shop—and I didn't know that was there but we just parked right across, a Target was next door. So I just stayed in my

truck, and I watched and I realized that that was a smoke shop and I watched it for about 15, 20 minutes. I just could not believe the number of people going in. At the end of that 20 minutes or so, I was talking to my grandson and says, watch - help keep count because I can't keep up, I said. But within that 15, 20 minutes we saw about—I'd say at least 110 people come and go from that place. I was just amazed at the number of people there. And then some of these people weren't just coming out with packs, they were coming out with cartons. So I told my son, I'm gonna go into the tobacco business and make a lot of money, I said, because they had to have been making a lot of money. I mean, you know, individuals would come out with two or three cartons of cigarettes, and there were at least a half a dozen that I saw do that. So there's a lot that we need to do among our own communities. Most of these—or in fact, all of these individuals, were not Indian but it just kind of gives you a picture of how much – how many people do engage in cigarette smoking and so forth. So I wouldn't doubt it if we - our own people are just as much—a very, very active part of that population. But that was really interesting that I saw and observed sitting out there looking at people.

Director Cathy Abramson: Anybody else? Thank you very much. That was very interesting. Yes?

Counselor Derek Bailey: Only two things here. Just to recognize that also this week, Friday from 9 to noon IHS director of the Bemidji area listening session going to be held at this resort and a flyer for this weekend powwow, our tribe's powwow, going to pass that around. Please see me if you have any questions.

Director Cathy Abramson: And just a reminder, please silence your cell phones to anybody out there that has cell phones. And we get a 20 minute break because we are so good.

END.

Environmental Health Panel

Director Cathy Abramson: We'll start with our Environmental Health Panel. We have James Stephens, Acting Deputy Director for the National Center for Environmental Health, and Judith Qualters, Ph.D., Director of the Division of Environmental Hazards and Health Effects. And they're both from CDC. Was there somebody else that might join them? I'm not sure.

Director Cathy Abramson: Okay, welcome. Thank you.

Dr. James Stephens: Thank you for the invitation to come and speak. I'm Jimmy Stephens, Acting Deputy Director of NCEH/ATSDR. I understand from some of the past TAC meetings you expressed an interest in environmental health. I'm really delighted to be here today and there's sufficient interest for us to come out and have a nice chunk out of the schedule. I was also delighted to hear that you wanted a relatively few number of slides in our focus on discussion. That's great. This is my first TAC meeting in my position in NCEH/ATSDR but I did attend a TAC meeting a couple of years ago in a different job, and I was really amazed at how much I learned from that meeting and how useful it was and how important it was to be able to hear your concerns and challenges and to understand how to better engage, and I think we should keep it all in. So I'm really looking forward to the discussion this is a very important. So Judy is here. Judy is the Director of the division that houses in partner and hold two of the main issues that I understand the TAC is interested in the past and it's water and climate change. So I'm gonna go through the slides, but we'll all be available for discussion and questions after.

So the first topic that I understand there is great interest in was water. Of course, water disinfection is a great public health success story from the last century and led to a dramatic decrease in water-borne diseases since 1900. Currently, water is regulated, in large part, by EPA under the Safe Drinking Water Act, and through the Safe Drinking Water Act, EPA regulates drinking water supplies in about 155,000 water systems, and that covers about 85 to 90 percent of the U.S. population. Through the Safe Drinking Water Act, the EPA sets maximum levels for over 80 contaminants and that includes both organic and inorganic chemicals, metals, and all sorts of organisms. But the Safe Drinking Water Act does not regulate drinking water systems that serve fewer than 25 people or are in different connections, so these private wells and unregulated small drinking water systems and the federally unregulated drinking water systems serve about 45 million Americans. So the problems with the unregulated systems, of course, in the first place, there's a lot that is not known about these systems including basic things like where the locations are, the populations that are served, and the potential contaminants and other risks that are associated with these unregulated drinking water systems. There are some small studies that have found in specific instances unsafe levels of contaminants in private wells, and they're a few listed on the slide. But there's still a lot we don't know about the unregulated systems. Some of CDC's activities around unregulated drinking water includes characterizing exposure to health risks and health impacts, and our role in NCEH/ATSDR is in the non-infectious drinking water contaminants. And we currently have worked with USGS and academic partners to model potential contaminants in private wells. We are developing guidance on developing effective evidence-based interventions around drinking water and really working with various groups to identify ways to get people to test their well water and implement it in emergencies if necessary. And then we are also responding to

environmental emergencies that impact regulating drinking water. For example, there was a recent publication looking at resulting focus work - focus groups with individuals in Arkansas, Indiana and Oklahoma, looking at public health concerns around drought and how has affected the drinking water supply.

Two tribal activities that I wanted to highlight. The first is the Navajo Water Hauling Studies, which is from 2006 to 2010, and there's about 14,000 households, which is about 30% of the households in the Navajo Nation, that are not connected to public water, so the majority of the households are using water that's not regulated in the Safe Drinking Water Act. In some remote places, water is hauled to households from untreated sources, such as ditches and agricultural crops. So between 2006 and 2010, CDC worked with Navajo Nation and EPA to characterize the risk of drinking water in certain areas. Conducted a survey of households to confirm the sources of water and potential health risks, identified unregulated water sources that exceeded allowable arsenic levels under the Safe Drinking Water Act. Worked with the Navajo Nation and EPA to develop education materials for the community on health risk and water testing, and the results of this work will be used to inform water hauling services.

The second activity, as I mentioned, is an ongoing effort for the National Tribal Water Council, and this is a project to assess the knowledge, health attitudes and practices related to water systems among tribal members.

Let me move on to the second area that I was told was of great interest to this group, and that's climate change and health. So there's a lot of concern about climate change. Our specific role is looking at the health affects that might be associated with climate change, and I've listed sort of four major categories of health risks here. The first one is extreme heat. It's interesting that extreme heat is actually the leading weather-related cause of death in the U.S. So, for example, from 1999 to 2009, extreme heat exposure caused almost 8,000 deaths in the United States. And then there was also additional morbidity associated with that and increased hospital admissions, for example. As one example, in 2006 the California heat wave resulted in 16,000 visits to the emergency departments. And we know that extreme heat events are increasing in the United States, not only in frequency, but also intensity and in how long they last as well.

The second area of health impacts is related to reduced air quality. So increased temperatures can increase things like ground level ozone, smog that's why in the summer, of course, you have more bad air days, especially in urban environments. Also those expected to increase the frequency and severity of wildfires. There is some evidence wildfire season has already increased by 7 or 8 days on average and the duration of fires is, like I said, due to the increase of smog. And, of course, wildfires traditionally obviously starts with the fires

themselves create particulate matter in ozone and you have health impacts far beyond the location of the wildfires.

The fourth area I want to talk about is vector-borne diseases, so diseases that are carried by, transmitted by insects, and that includes things like for instance increase in Lyme disease due to increased tick populations or mosquito-borne diseases from increase in mosquito populations. And then finally, extreme weather itself can have an effect from extreme precipitation events, heavy rainfall, flooding or on the other side drought, deaths from drowning, respiratory illnesses related to having damp indoor environments, dust storms. And then also related to previous slides on water quality, these events can also reduce the quality of water sources. CDC has the climate-ready states and cities initiatives. This is looking at enhancing the capacity of state and local health agencies to get the feel of challenges. We have the BRACE framework, Building Resilience Against Climate Effects, which can be used by organizations to help prepare for the results of climate change, and Judy can talk about that in more detail when we get to health effects.

Let me just go through just a few other things quickly, there's a - which you may or may not be aware of - there's the Navajo Birth Cohort Study. This is looking at areas, which since the 1930's, have had extensive uranium mining and milling in the Navajo nation. And while there's been many studies of environmental and occupational exposures to uranium associated renal affects in adult populations, there's very few studies of other adverse health effects. The goal of the study is to recruit 1,500 pregnant mothers, evaluate their exposure and the exposures of their unborn child and then follow the children for adverse birth outcomes and development delays and the goal is to follow these children for two years after birth. The results of that are anticipated 2015, I think. Landfills is another area we've done, we've had some site-specific work on landfills a number of places around the country. Some of the common exposures concerns here are listed on this slide. Probably the leachate contamination probably is the most common. I did also want to point out this third bullet on odors and air quality. ATSDR has recently posted a website that's on odors, and it's a great resource. You can go and you look up, even search for odors that maybe smell like such-and-such that it's just likely we have a lot of frequently asked questions and advice on what you can do if you're concerned about odors. And then finally I'll just mention a couple of other things we're working on. Environmental Public Health Tracking. So public health tracking is the ongoing collection, integration, analysis and interpretation of data about environmental hazards, exposures and health effects that are potentially related to exposure to environmental hazards. And I wanted to highlight this year, the environmental public health tracking program launched in partnership with the Bemidji Area Tribal Environmental Public Health Advisory Committee and the Great Lakes Inter-Tribal Epidemiology Center to assess and begin to plan how different data sources can be brought together to link

environmental and health outcomes to the tribal level and work towards enhancing information sharing and collaborations and communications in the agencies. One final topic is radon. Radon is the second leading cause of lung cancer after smoking. And there's a Federal Radon Action Plan with the goals of raising awareness and creating centers on the use of radon exposure in homes, incorporating radon testing and mitigation with federal partners investing in new standards practice and updating codes for the measurement and mitigation of radon and establishing the center's dry...testing and mitigation in private and public sectors. And CDC has been working with EPA and others on helping to raise awareness of radon and encouraging people to incorporate radon to healthy home activities and encouraging partnerships around radon.

So with that, that's a very broad coverage of a lot of different things. I mean, if there are other environmental health issues that this group is interested in that I didn't list on the slides, I will be more than happy to respond to any questions.

Chairman Herman Honanie: Hi, good afternoon. Herman Honanie, Hopi Tribe. I'm just kind of curious about the arsenic matter. I think a lot of tribes in the Southwest, including Navajo, has that challenge, has that issue and problem at present. So my question generally is, is there any component from your department that's really strictly putting a lot more study of this particular issue, and what progress has been made in studying arsenic? I think someone did explain where it comes from or where it generates and so what can really effectively be done to water systems now at this point when they're being found? I know it's supposedly a really, really costly step to be able to mitigate the presence of arsenic. So could you speak about that a little bit more?

Dr. Judith Qualters: So arsenic is actually a priority for us in moving forward in our strategic plan in my division. Arsenic, uranium and the nitrates is the other area that we're concerned about, too. Those two, arsenic and uranium can be naturally occur and cause significant health risks. So we are doing a couple of things. Jimmy mentioned one. One is, you know, a lot of this is private wells, so we have been trying to get a better handle on the data that's available that's out there and what isn't available so we can get a better handle on what's really going on with private wells. This was started a couple of years ago with what we call the Private Well Initiative, and we're continuing to move forward in looking at how we can utilize data that's working with states and states have been able to identify in order to understand what the level of contaminants are, so not just arsenic but other things. The other thing that we're doing is, since these are private wells and it is hard to get that type of data, we're also working with USGS and others to look at some of the ground water sampling that they regularly do to see if there's a way to statistically model that data so that we can get an idea of who would be vulnerable to higher levels of arsenics based on some of these statistical miles so we can target where to do interventions. The third thing we're

doing is really looking at and working with the National Private Water Council, and getting a better idea of how some of the tribal communities, what their sort of knowledge, attitudes and beliefs are around the water that they're using and not only their private wells in terms of how they test them or what sort of testing is done, but also sort of the infrastructure, the water system infrastructure and how sort of their ownership of it and what may be blocking a more sustainable infrastructure for tribal communities. And then, I could say the other thing we're doing is we're looking at what are potential interventions, and we hit on it - one of the ones we know we have tested in some places is related to what's called reverse osmosis that can be used to remove arsenic. It works well for one type of arsenic. We need to add another piece of equipment for another. It can be installed inside the home or outside the home as a whole system, but it can be expensive and the parts can be expensive. So are there more cost effective ways and what are the cost effective interventions that can be utilized. And if that is the best thing, what are ways to partner with others to try and get knowledge about that. So I hope that answers your question.

Chairman Herman Honanie: To a point it does, yes, because we have a huge presence of arsenic on the reservation, and right now, we're doing what's called a Hopi Arsenic Mitigation Program. All we're doing is basically drilling a couple of wells away from all the communities, and we're going to have to pipe it into the communities that are adversely affected by that which is really going to be costly. It will, I guess, resolve the situation but at the same time right now people are consuming it, so the question with regard to health is what happens when people have been drinking water with arsenic all their lives pretty much?

Dr. Judith Qualters: I think it depends on the level of arsenic in the water. There's certainly - there's a standard for arsenic that the EPA has set, so it's not zero. Off the top of my head I'm blanking right now on what it is, but so it depends on the standard that has been set and what the level is in the water. You know, there have been studies that have looked at very high levels of arsenic as it relates to skin issues and cancer, other things like that. But again, it depends on the levels that people are exposed to, so there is a considered safe levels that are regulated change but there is a safe level right now or a level that is considered acceptable. So I think it would depend on what the levels are to be able to say what the risk was. I know this is an issue for your part of the country, it's an issue certainly for the Northeast and other parts of the country, too. It seems to be sort of a cross country issue.

Chairman Herman Honanie: So one final question. You state, and I've heard this before, too, it's naturally – it occurs naturally. What and how does it occur?

Dr. Judith Qualters: It's some of the heavy metals like arsenic, uranium and others are part of the earth's crust. So whenever you dig into the crust and you get to areas where those metals tend to be available, and so that's where they come from. Now, that doesn't mean that there aren't manmade and other processes that also generate those types of metals, but really the private well is one of the biggest issues is just digging into the earth's crust where those metals exist.

Council Member Patty Quisno: It wasn't mentioned in part of your presentation, but I'm wondering about mold because it is water connected. We've had several floods in Montana and several reservations have been affected very, very much by mold. Can you tell me about the different kinds of mold? I mean there's mold that doesn't seem to be harmful and yet there's mold that just—there's a man in our area that is - he's lost 40 pounds. He is very, very sick from some kind of mold.

Dr. James Stephens: I'm not an expert on these different kinds of molds. I know we have, we hear a number of different documents and there are some guidelines developed after Hurricane Katrina and a few were around mitigation. I know there are some documents out there I can connect you up to some of them. I think, I know the last time I worked in the community there's a lot of unknown in terms of mold exposure including and what the health effects are but I think there is a pretty well established process).

Council Member Patty Quisno: That are left, aren't there? I mean I hear about toxins in relation to mold.

Dr. Judith Qualters: I have to defer to our mold expert.... But I think part of the issue is the days and days after flooding that there's really—there are guidelines in terms of how to clean up. We went through this with Sandy and other after storm response in terms of being sure that things dried out appropriately and making sure people have the correct guidance....and others to, you know, how to clean up so that they

Council Member Andy Joseph, Jr.: Up on Colville Indian Reservation, we have the Great Columbia River and our neighbors across in Canada, Teck Cominco has a mine up there and they dump their slag into the Columbia River, and I believe it's affecting a lot of our people because of the different cancers that are coming up, but also when they run their smelter, the air-borne chemicals that drift down into the United States are - you know, it settles and goes into the streams and up into our lakes and the bottom, the fish that have to live in that water have high levels of mercury and different other toxic chemicals that I guess it could lead to like irritable bowel syndrome and different illnesses. That's one issue. Another issue that I really worry about nationally is the clean water, what you're

doing to, I guess, regulate what's being allowed with all of the oil and gas exploration, the fracking that happens. I'd like to see a map of how much area there is of the United States that has - actually has any clean water left. Hopefully, we're not going to end up like China and have to clean seawater to bottle up for people. I'd hate to see these great lakes around here become contaminated with all of the different fracking that they're doing. It's gotta go somewhere, and I think we need to be let known what chemicals are being put into the aquifers and if they're gonna cause us even more harm than what it's really bringing forward.

Dr. James Stephens: Thanks for those comments. We've had a little bit of engagement on fracking, for the most part, our goal has been to support EPA because EPA regulates the contaminants in water. We have done several site-specific—I think we've done some health assessments at about 10, I believe, fracking sites. It's turned out to be fairly challenging for a couple of reasons.

One is that in a lot of cases, we don't have the baseline data, so we can't go and look at the same thing when the fracking started...affecting the water quality and sorting out it was due to fracking. And then the other thing is these - forget what it's called - the liquid that's used in fracking is a proprietary mixture so we don't always know what's in there. But there have been a number of discussions among federal agencies and we've been at the table based on the health impacts because there's a lot of concern about fracking involving these health impacts.... Like the GSBS, EPA and EDOU that are leading the efforts looking at fracking run-off.

Dr. Judith Qualters: They actually just published their plan, so we can provide the link to that...

Ramona Antone-Nez: Ramona Antone-Nez, Navajo. Thank you for your presentation. In a follow up question to what was brought up by a tribal leader about mold, what are the significant impacts of health when exposure to mold happens as related to asthma? Does your office have such information? In addition to the question, what activities or programs are available from your office or from CDC to Indian Country regarding mold? Another question that I have about fracking is I understand that you just provided the other offices that provide guidance, and I'm curious about the published plan in terms of whether there's research that's available through your office or if you could assist us with access to resources on the health impacts of fracking water - to the water supply. In addition to those two questions, I just want to also share with you that we do appreciate the Navajo Birth Cohort Study that is being conducted here at the Navajo Nation, and the Navajo Nation has continued to advocate for a long term study on the health impacts of uranium contamination exposure and

environmental health cleanup efforts. We understand that there are some efforts that are being made; however, because of the long, the half life of uranium and the byproducts of uranium, we will continue to advocate for that need to be addressed. I do have a question about the comparison of uranium in the Southwest regions, as you had put it, as you have talked about your Navajo water study in comparison to the non-Southwest regions. Are the contaminants much greater than other regions? And I also think that—I can imagine in my mind that there's a mapping of the different regions of Navajo and there are places where are identified for water wells to not be used by humans, like it's regulated. However, the water is still being used for consumption by our livestock. So I'm just curious if those connections are with your office or not. That's a background question I had for you. The other is, as you will hear in our testimony tomorrow, that the Navajo Nation recommends to ATSDR to provide additional funding to support a position such as an epidemiologist, a statistician, a data manager or demographer and health educators that would address both the Navajo Birth Cohort Study but also the other health issues, or environmental health issues that are on Navajo. Just want you to be informed since we're talking person to person that these are part of the testimonies that we have. We also have another leading cause of mortality is unintentional injuries on the Navajo Nation, and we see this as an environmental issue and we will advocate as we did during the February meeting that funding allocations be increased to prevention activities, how your program or your ATSDR relates to and helps with the funding allocations is one of - something I need to learn and understand better but because of the unintentional injuries as related to how our environmental health and public health issues are addressed, that would be part of the justification for additional funding. Thank you.

Dr. James Stephens: So I'll try to respond to the things. Some of the points I'd forgotten so Ms. Antone-Nez let me know. So the first one's on the mold, I think maybe the best thing would be if there's a particular mold, maybe you can get some materials that have already been developed that will be number one ...so if you are interested you can talk to me and we can get you some of that material.

....Or if you identify any gaps in material may need to develop additional material You asked about fracking, and I'm sorry, I've forgotten what was the specific question

Ramona Antone-Nez: I just want to go back to the mold issue in terms of the relationship to asthma, if you have the rates on those as it impacts health? And back to the second one about fracking just to continue on is what research and guidance is available regarding the impacts of fracking to the water supply? Thank you.

Dr. Judith Qualters: So I can't give any numbers on how much asthma is attributable to molds, but I can tell you that mold is a trigger for asthma attacks, along with other indoor allergens and outdoor allergens. So it is a trigger. You asked specifically if we have some programs related to mold or asthma, specific for Indian Country. And right now we do not, so I think you have to work with many a number of states but we do not have any programs that are specifically targeted to Indian Country so that's another gap. I think that was all the asthma things. The other is the health impacts related to fracking and specifically related to the water supply. I think there's not a – I'll start - So there's kind of a dearth of epi, epidemiologic literature on fracking. I think that we don't know a lot about the exposure to begin with to really know about the health impacts. As Jimmy said earlier, ATSDR had done some health consultations and public health assessments and those will be available on the web, and we can get you a web link for those. Those would be very site-specific in addressing specific questions. There was—if I could find it—there was, I know, a recent review of the literature and there's not a lot of literature but I'll see if I can find that link to share with you guys about fracking and what we know and don't know related to health. And then in terms of water supply, I think the issues that have arisen in the general discussions have all been around two areas. One is obviously does it result in contamination of ground water and then the other one is related to water availability and resources especially when you have areas that are impacted by drought because it uses a lot of water.

Dr. James Stephens: I think we have – I think up to ten sites where we've done – 10 or so sites - we've done fracking, I think all of those publications are available on our website, I think all of those with the exception of one of them is ready for public comment. I think you'll look at it and you'll see what some of the challenges are. I think as Judy said, in a lot of cases—normally our role is to support EPA. So EPA is going in and doing the sampling and looking at sort of what the exposures would be and looking at the health impacts. I guess my general take at this point with fracking is that there's—as Judy said, there's a lot to learn about the exposure so I think we're still in the very early stages. One of the other points you mentioned was unintentional injuries. I actually just recently came from my previous job as deputy director at the injury center, so I won't try to speak on their behalf. Of course, that would be in their area.

Council Member Andy Joseph, Jr.: I always wanted to know if there's ever any studies on boarding school children that—I know for a fact that the big boarding school that I went to down in Brigham City, Utah, Inner Mountain Indian School, was shut down because all of the pipes were wrapped with asbestos. I just - we didn't know what those pipes were wrapped with and we used to do chin-ups on them. Being kids, we were - used what we could to exercise with. But I know there was a lot of risks that we're exposed to asbestos for quite a few years in our lives, and I was always wondering if anybody ever studied to see if that impacted the students. They shut that school down because of it.

Dr. James Stephens: Yeah, I don't - I haven't heard of anything. I mean, there's certainly a lot of literature and a lot of information on. asbestos exposure and remediation. I'm not familiar with any study specifically.

Dr. Judith Qualters: You had one other question related to uranium and the water hauling studies. Those were a series of studies over time with the Navajo Nation and Navajo EPA, and I know the results of one of them—well, one of them actually did supply one and so they looked at the levelssamples, and what they found was that the levels were higher than the U.S. population and probably comparable to the Southwest population.....

Chairman Herman Honanie: Herman Honanie. On what you just stated with regard to the water hauling system and so forth, since I guess we're in the neighborhood of Navajo and we still have a lot of people hauling water for domestic use as well as for our lifestyle. Now, could that same assessment in the study be applicable to a general area?

Dr. Judith Qualters: I think I'd have to look at the studies again and read because I know the original study identified, sort of five regions that were of higher risk...And then the second study went in and looked more specifically at what people were actually being exposed to. And I think there was a third study and then there was a study since then..So I think it's - it was targeted at specific areas and I would have to go back to investigators to get a better idea of how generalizable they thought the results were to other areas.

Director Cathy Abramson: Have there been any studies done on finding crafter ways to mitigate pharmaceuticals to clean water?

Dr. Judith Qualters: We have not done any. I do not know. I'm sure that there have been some. We could probably look and see what's out there but we have not done any.

Dr. James Stephens: Yeah, the studies I'm familiar with were not done—were not our studies essentially the studies looking at trace wells and water supplies. I don't have a good sense of what the studies are, I think that's a technicalstudy.

Dr. Judith Qualters: I was saying I don't know if the focus was really mitigation at this point. Just trying to quantify what was in the study.....

Director Cathy Abramson: Is, could you illustrate how you worked with IHS Environmental Services? Do you?

Annabelle Allison: For the Navajo Birth Cohort Study, we are working with the Navajo Area Indian Health Service. We've actually provided some funding to them to be able to get the necessary equipment in the laboratories.....templates.. And then we've also worked with them in terms of recruiting and then the National Tribal Water Council, they are working really closely with IHS.....

Dr. Judith Qualters: Thank you. Ancient history. I know when we were first doing some information gathering, these are requirements gathering, around the tracking network we actually pulled some folks in from Indian Health Services trying to get an idea of what type of data they could use and how they would do something like that

Board Member Cathy Abramson: Thank you.

Chairman Herman Honanie: I have a question with regard to your landfill presentation. Could you explain the first bullet that you have there regarding Leachate contamination of surface and ground water?

Dr. James Stephens: Yeah, so basically what that's - so landfills normally—at least modern landfills, have liners and an open path to prevent water from leaking through the landfill and taking contaminants off and they've got barriers in place for decontamination either if it's an older landfill that doesn't or something that barrier's...so concern ...if not being held there...water's coming through and taking contaminants off . And, of course, then this can be a special concern if this is going to create some sort of hazard.

Chairman Herman Honanie: My other question has to do with the long drought that especially the Southwest is having - experiencing and I used to hear about rain cloud seeding and things like that but it just seems like there's so much talk about the drought but in effect, what, if anything, is being done to mitigate it in any way whatsoever to work with mother nature?

Dr. James Stephens: I'm not sure we have an answer to that. But I know we talk about thatand also the drought.

Dr. Judith Qualters: I don't think we have an answer to how to mitigate mother nature, but I do think part of the work of funding a health program is to help communities identify what their vulnerabilities are, who the vulnerable populations are and what their efforts would support. So in the Southwest, in California, the last few years, there's been a drought that's hitting hard. Last year was a big year for facilitation and flooding in other areas. So what we're trying to do is work with folks in terms of predicting what is the biggest problem they're going to face and to think about how to address that. So if it's drought, what do we need to think about in terms of (inaudible). What are we thinking about in

terms of hauling water to keep the population healthy? It's flooding, it's storms you know it's (inaudible word) to work with partners to (inaudible word) the buildings, (inaudible), and to take other actions that helps impact our health of the communities. (Inaudible) droughts, sandstorms probably. That's not a good answer. We don't have any way to mitigate the drought. We just have to talk about in terms of whether.. systems can be put in place that actually help people that are affected by it. And it is something that will have a health effect.

Ramona Antone-Nez: Thank you. This is Ramona Antone-Nez. I am just thinking about my home and that is in Navajo. We recently were – we recently combated, if you will, a wild forest fire that had taken place and what our emergency command officer had informed us about through the emergency preparedness is the next thing that we should – the next events that we should expect is floods from the thunderstorms and the rainfalls that come, and we have a lot of wash-away that happens from the erosions and flashfloods, etc. I'm just curious about this - your slide that talks about climate and health, Climate Ready States and Cities Initiative, Building Resilience Against Climate Effects framework, and I'm curious about that possible framework working with emergency - public health emergency preparedness. Is that part of the collaboration in that framework? And secondly, in that same light, can you see down the road that perhaps your center, the ATSDR, would be able to put on this particular bullet climate ready states, tribal and cities initiative to bring us to the forefront in terms of our territories, our lands, how can we address these climate changes and preparedness, because part of the issue that we have is states might get funded through a federal agency; however, the services and the objectives and activities that are claimed in those funding streams may not necessarily get to the tribes, which have been identified in the actions plans, the activities, or we're brought to the table after the fact, or we are consulted via telephone ten minutes, and it's a checkmark that, okay, that's tribal consultation, that's tribal advisory, that's the way we worked and therefore make that particular scope of work activity. So I'm just doing a down-the-road, is there a possibility to see climate ready tribes, state and cities initiative? Thank you.

Dr. Judith Qualters: So I'll take the last one first and I'd say yes. I think there's an opportunity to see climate ready states - local, state, territorial and tribal initiative, and we are actually—it wasn't on the slide—we do have one project right now that is working –doing some work in Alaska looking at some three different sets of communities and seeing how climate and the changes around it may impact the several different sections of the states. I think it's seven communities. So they're looking at groups in the southeast, west, they're looking at some groups in the interior and then in the (inaudible word) regions to see, you know, what they're observing in terms of changes as it relates to weather and how it's affecting them. And certainly in the northern part, it is primarily Tribal Native Alaskans and other groups and certainly a big issue for them is food security and

addition to changes as it relates to pollen and other allergens and increase in respiratory diseases that they've heard before. So we are doing some work in that and I could see that expanding also to other tribal groups. What's the other question? Oh, emergency response. I think we think of the climate and health program and the work that we're doing as definitely having a link to emergency response but not being totally an emergency response situation. So definitely thinking about it when we get into those situations of extreme weather and what might be the health impact of those. And then issues around wildfire, and then also the other issue is, you know, the issue around climate is that we are looking at is if you increase CO you increase heat you have longer pollen seasons. So, we have other things going on with—for instance, we have geographic framing for Lyme disease and other things. So emergency response is definitely linked so we try to link to that but we also try to go beyond that in terms of preparedness.

Ramona Antone-Nez: Thank you so much for all the time that I'm taking. I just want to say another addition to your climate change and health slide when you talked about the vector-borne diseases. In the Southwest, particularly one of the vector-borne diseases that we are cautioned of in preventing or treating is the Rocky Mountain spotted fever. As you just described how with the climate changing and having shorter winters and one way of having the ticks are living longer or they don't have a die-off season, etc. So I'm just - for this tailoring, I'm not really sure how Rocky Mountain spotted fever may or may not affect other Indian communities but in ours, I could see that as an effect in our region. Just FYI. I'm sure you already know that thank you very much.

Chairman Herman Honanie: Part of what she said, it's interesting and one of my personal challenges is having to do with vectors and other small animals and their presence and their impact on our farming. I'm talking about packrats and especially prairie dogs. Years ago, my dad would bring some strychnine and mix it up with some ground corn and spread it around the outskirts of the field and the problem would go away. But now we can't have access to any of that thing, so it's really a challenge. I farm along with about seven individuals totaling about maybe – I don't know - maybe 15 acres of corn, and I'm on the outskirts of it and I have a colony and I've been battling these varmints for years. I've tried everything, literally everything, and sometimes I'd sit out there and shoot them and my son was out there too. So I'm just wondering because they're damaging our livelihood, our subsistence, our corn. And then this past summer, my corn has been wiped out. It's been my whole acre—one acre of corn has been wiped out just because of the lack of rain and then plus these presence there. So I'm just wondering what can we do and how can you all, when you're talking about working in this area, what can be developed or what can be done and what are other parts of the countries doing to deal with this kind of challenge?

Dr. James Stephens: So a lot of that is kind of getting outside of the scope of our Center-NCEH,..... USDA but I did want to make a point though, I think related to both of those last two .around climate change. I know that Judy and her folks...told me. The other thing, I was handed a sheet here that's talking about partnership for prevention of Rocky Mountain spotted fever on tribal landSorry? Report?

Okay, yeah. Good point there. We also partner with the Division of Vector-Borne Diseases...NCEZID

Chairman Herman Honanie: Okay, thanks. Well, I just bring that up in hopes that—I know this is kind of outside your scope but I just bring it up just so that maybe you and others can knock on somebody else's door and somebody else can knock on somebody else's door and we can get some information at some point in time. Thank you.

Director Cathy Abramson: Was there anything else you wanted to share with us? Thank you...anything else? Well, thank you very much for presenting and being here. Before we have Romana come up and do our final wrap up of the day, we are going to go ahead and go into the—okay, well, I'll just inform you that we're gonna have Romana do the special wrap up and then we'll have our special session for smoking right after that. Then we'll probably be out of here sooner. So Ramona?

Ramona Antone-Nez: Chair members of the community, this is Ramona Antone-Nez. Before we actually close for the meeting and do the wrap up, I'd like to propose to the TAC committees, a Tribal Caucus of Tribal Leaderships tomorrow morning at 8:00 to 8:30 prior to the actual start of day two. I'd like to make that recommendation and request for support from the tribal leaders in that tribal caucus. I would like to also invite technical advisors to the tribal leaders just for caucus along the tribes prior to meeting with the federal representatives and guests. Thank you.

Director Cathy Abramson: Okay, so there's a motion to have a - to meet a caucus with the TAC and the technical advisors tomorrow morning at 8:00 o'clock. Is there a second to that?

Secretary Shawna Shillal-Gavin: I'll second that. Shawna Gavin.

Director Cathy Abramson: Second from Shawna. So motion and support. All those in favor signify by saying "I". Those opposed? Oh, well. Abstain. So how many do we need for—well, anyway our leadership wants to have a caucus

tomorrow whether we have a forum or not, we will have it at 8:00 o'clock, 8:00 to 8:30 so be there. Okay. Pardon? Now we'll get our wrap up with Romana.

Romana Fetherolf: Good afternoon. I'm Romana Fetherolf giving the afternoon highlights. We talked about tobacco usage and the use of traditional tobacco in ceremonies promoting that instead of commercial tobacco. Director Abramson mentioned the federal public health law training sponsored by NIHB on Thursday for anyone who's not attending the site visit. It's free to attend, and we'll be discussing how to draft public health law which could be a good use for the tobacco topics that we discussed. And Director Abramson also mentioned an article recently published by the Great Lakes Epi Center on Patron Perceptions of Smoke-Free Environments in Casinos. If you're interested, contact Kristin Hill with the Great Lakes Epi Center. Following that, we had the environmental health panel and a lot of discussion came up on fracking and mold, and we will work with Dr. Stephens and Dr. Qualters to get information out to the TAC members. And there was a motion to have a caucus with the TAC members and tech advisors tomorrow morning from 8:00 to 8:30 which was voted on and passed. If I have missed anything, please let me know, and I'll add it to the minutes. Thanks.

Director Cathy Abramson: Okay, we'll do a closing ceremony, a closing blessing at this time. Andy, would you like to say a closing blessing for us, and then we will stay here so we can have the special session

Closing Blessing
(Not Recorded)

CAPT April Shaw: So for the special panel – I mean, I'm sorry, special session from Office of Smoking and Health, they are going to give us a ten minute break, and then they will sit where the presenters were sitting, but this is an open meeting where dialog can be with everyone. This is not anything official with the TAC, but they would love as many people as can to stay. Thank you.

END.