

**CDC/ATSDR Tribal Consultation Session
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Councilman Chester Antone: I'm going to ask that senior leadership not sit at the table at this time. We just have the TAC membership sitting at the table, and we'll announce when you can come up to the table. This morning, I've asked Mr. Tribal Chairman of the Hopi Tribe, Herman Honanie, if he can do the blessing for us this morning and then we'll get started.

Chairman Herman Honanie: [Talking in Hopi] . . . thank you.

Councilman Antone: Thank you, Chairman. I also want to acknowledge that Michell Hicks from the National Area is here. He had some problems coming in yesterday, so – but I'm glad he's here with us today. I'm going to turn it over to CAPT Wilkins who has some announcements before we begin.

CAPT Craig Wilkins: Good morning, everyone. Just a couple reminders and housekeeping updates. For the TAC members, for lunch, if you want to order, again, your lunch from Panera, fill out the form and you can give that to Miatta Dennis, the same person from yesterday. When Dr. Frieden is here, during our first break, we're going to have a photo opportunity for the TAC members with Dr. Frieden. We'll let you know the location when a photographer gets here. Attendees, again, during our closing session today and during our tribal testimony, we ask that you not leave or come into the room at that time. A reminder of the CDC exhibits that are out in the foyer, that if you didn't have opportunity to see those yesterday, they will be out there again today. Finally, please shut off or silence your cell phones, laptops, or any other electronic devices. Thank you.

Councilman Antone: Thank you, Craig, and I'm going to turn it right on over to Judith A. Monroe for the OSTLTS update.

Dr. Judith Monroe: Thank you, Chairman Antone, and good morning everyone. I hope everyone had a good evening. I certainly enjoyed getting to know folks at dinner last night, so thank you for that. So in the next few minutes, I wanted to go over our Office of State, Tribal, Local, and Territorial Support, especially for the new members of the TAC that would be less familiar with OSTLTS, and our office was created under the leadership of Dr. Tom Frieden who will be with us later this morning. Dr. Frieden saw a need to have a crosscutting office that would really be here to support the field, support all of our work in the field, and to support – by being a crosscutting office, we support all of CDC as well, all of the programs, in one way or another. We're here as a support office, and so for that reason, these are the three strategic directions that CDC, as an

agency, have adopted in the last couple of years. We've been focused on improving health security at home and around the world, and when we think about that, certainly with air travel, the outbreak of a disease anywhere in the world can be essentially in your own backyard within hours, and so there are a number of things that we do. And it is, I think, important to understand that CDC really is a global agency. Our work reaches around the globe. We have staff in multiple countries, and for that reason, our director is pulled to many, many urgent issues in any given day. The second strategic direction is to better prevent the leading causes of illness, injury, disability, and death, and I know that that strategic direction is one that is very important to all of you. And we had a discussion yesterday, and today, I'm quite excited about our round table discussion with the senior leadership where we'll dive deeper into many of the issues with the second strategic direction. And then the third strategic direction is strengthening public health and healthcare collaboration, and this has really emerged with the Affordable Care Act and the work and the movement across the nation to focus more really on population health and to change the way healthcare is paid for. It's opened up a wide opportunity, so a number of federal agencies are working together on this strategic direction. And so being in OSTLTS, being in our office, we support all of these strategic directions, again, in one way or another, which I'll get into a little more detail here.

So this is the organizational chart. Again, especially for the new TAC members, you can see Dr. Frieden and then Principal Deputy Director is Ileana Arias, our leaders, and then you can see the Office for State, Tribal, Local, and Territorial Support – I'm one of four Deputy Directors that reports to Dr. Frieden, and then you'll meet today several of the Associate Directors. There's an Associate Director for Science, Communications, Policy, and then we have a CDC Washington Director as well as then our Chief Operating Officer, the Chief of Staff, Office of Diversity Management, Equal Employment Opportunity, and Office of Minority Health and Health Equity. So all of those are direct reports to Dr. Frieden, and then you'll meet I believe all of my fellow Deputy Directors, Dr. Chesley Richards, Dr. Robin Ikeda, and Rima Khabbaz, Dr. Khabbaz, later today. And then, within OSTLTS, our structure – Steve Reynolds who is here – Steve might put his hand up there – Steve Reynolds is my deputy in OSTLTS and then you can see we've got CAPT. Craig Wilkins who you all have met directly reporting to our office, and we appreciate the work that CAPT. Wilkins has done over the last several months for us.

So our overall mission in OSTLTS is really to think about the entire system. Again, if we're in an office that's supporting all of the folks in the field, the health departments, and partners, tribes, and territories and so forth, then we try to think very systematically and have been focused on advancing agency and system performance, capacity, agility, and resilience. So this is just an overview of the things that we do, and I've already mentioned the capacity and performance improvement, which I'll dive into a little

deeper here. We have training for new public health officials and so we have that actually ongoing now. They are downstairs, new state, tribal, local, and territorial health officials are in a special training today and were here yesterday as well. We give guidance on public health law and then we have a number of targeted communications, teleconferences. We have a special website and assessment tools, and we are very open to your ideas and requests and suggestions for how we can improve the work that we do in our tribal support unit to better support you and the tribes across the nation. And so one of the things that we have in place is – and this was new – and one of the things that we heard and have heard loud and clear is that direct funding to tribes is important. And so we have a Tribal Public Health Capacity Building and Quality Improvement Cooperative Agreement that was new and there were two priority areas – priority area one was tribal public health capacity building, and these are the grantees, the recipients of that funding, so funding went to the Bad River Band of Lake Superior Tribe of the Chippewa Indians in Wisconsin, and they are working towards – their journey towards wellness cancer prevention project. The Inner Tribal Council of Michigan has the Upper Peninsula Tribal Breast Health Coalition and Learning Collaborative, and the Kalispel Tribe of Indians in Washington, and that’s the Tribal Health Systems Capacity Building Quality Improvement projects that they’re working on to increase their health system efficiency and streamline processes.

Further, we have the Pascua Yaqui Tribe in Arizona, and they are working on identification, treatment, and prevention of hepatitis C among their tribal members and then – is it the Toiyabe Indian Health Project in California, and they’re focused on diabetes primary prevention programs for American Indians in California. And then we had a priority area 2 and the grantee there is the Native American Cancer Research Corporation in Colorado where they’re monitoring and evaluating for the five priority area 1 awardees, so we have an evaluation component in that. So that’s new work for us. The partnership support unit is very robust in OSTLTS. We have a unit that works with 23 national associations, and one of those is the National Indian Health Board. They’re one of our grantees, and they are – we’re quite excited about this because they are coordinating a tribal public health work group to provide subject matter expertise and advice to all of you as TAC members and to CDC. Then we also have the Association of American Indian Physicians. I think this came up yesterday in some of the discussions, and they’re completing several capacity-building projects affecting American Indian and Alaska natives. This came up when we talked about the Native Specimens Policy. They are working in that regard. They’re also working on a compendium of evidence-based intervention success stories from Indian Country. They’re working on data, going into action training, so it’s a 101 for tribes and urban Indian programs and how to access and utilize available data for local level public health action which we believe is really critical to improving health. And then the Native public health courses for schools of medicine, another big project, and tribal grant writing training to assist tribes in their technical ability to write grants. So a lot of work

under our partnership support unit. We heard yesterday about the National Public Health Improvement Initiative and the funding for that, but this shows you – this has been a large part of the work actually in OSTLTS over the last four years. This funding came to OSTLTS in 2010 just as the office was standing up, and this was meant for infrastructure building, and we created the National Public Health Improvement Initiative, so you can see the funding. We did have a reduction in funding from 2010. Our peak was at 42.5 million dollars, went to 76 grantees. It dropped down to 32.5 million in 2013. We did expect this to be a five-year initiative, and as we all know, with the omnibus, it has been cut short, so it's four years, but the work that has taken place with NPHII has been, I think, rather remarkable, and we've really been getting the gains here in the last year because it takes time to ramp up and for folks to really get the work done. This was meant to help accelerate accreditation readiness, but really, the stories that I've been hearing have been very robust in the performance management and improvement practices that have taken place, promoting practice-based evidence as well for the public health agencies.

So as an example on the state side with some of the grantees, we have a number of the large states like Texas and California. Hawaii is one of the states that have reported that they use NPHII funding to improve the process of getting contracts out the door. In fact, for the State of Texas, getting contracts – just a huge effort for their agency, and they just had thousands of contracts. It was a very high number, and they had their number one complaints around their contracting processes what they reported. By having this funding and this focus on improvement, they made a remarkable improvement in their process of getting the contracts out. Hawaii has reported that what used to take six months now takes six weeks as an example. California has reported that. A number of our states. We did award – these are the funding that went to tribes, and we've had a number of success stories that have been reported through NPHII from our tribes. So the Alaskan Native Tribal Health Consortium is an example. More than doubled the percentage of pulmonary clinic and cardiology clinic patients who use tobacco who were now being referred actually to the tobacco cessation program. So I think that's – it's a great example of what NPHII is all about. You have a tobacco cessation program in place. You have clinicians seeing patients but if the processes are not in place to make that connection, then we don't reach the full capacity. And so, as an example, in Alaska, they went from a referral rate of 8.4% to 20.7%. Now, of course, we'd love to see – there's room obviously to continue that improvement, but NPHII gave them that capacity to be able to make those types of improvements. Navajo Nations Public Health Division developed a quality improvement plan to assist in a number of quality improvement initiatives to give them that technical assistance. The Montana Wyoming Tribal Leaders Council developed community health profiles for Montana and Wyoming Tribes and served as technical advisors to the Tribes, implementing individual tribal community needs assessments and generated a public health code and public health infrastructure, building capacity awareness with the

Montana and the Wyoming Tribes. So you can see, it's pretty far reaching, and the work that's been done through NPHII has been diverse, but all focus on making sure that we're using our resources as wisely as possible.

One of the unique features of NPHII was that we required all the grantees to assign someone to be their performance improvement manager. Our preference was that this be a full-time position and that they report to leadership, and so in doing this, we created then a network across the nation of these performance improvement managers that could share best practices, share successes, learn from experts. So they have had monthly calls. They've had meetings, webinars, and an annual grantee meeting to support one another, so that's been one of the keys to the success I think of NPHII. This was the slide I was looking for, so I kind of jumped ahead and already gave you the details on some of those NPHII examples.

Another large program that OSTLTS has under our authority is the Public Health Associate Program, and again, especially for the new TAC members, this is, I think, a really important program for you all to understand. It's a two-year entry level program, so the minimum requirement is to have a bachelor's degree, and then they can apply to the program, and if accepted into the program, they spend two years in a health department with on-the-job training. It's hands-on training. What's interesting is that we have had – about 30-35% of our applicants have actually had master's degrees because they want the applied training. I think of it a little bit like residency training. You go through medical school and you have the book knowledge, but then you go on to residency training for that hands-on training. In this regard, you get your basic education and then you can go on and have this hands-on training in health departments. And folks have worked on a number of projects. It's been quite interesting, but you can see the growth of the program. It started in 2007. This was actually the kind of rebirth of a program that had taken place to develop the public health advisor many years ago, and it had stopped funding and resources had stopped I think in the early '90s, is that right Steve? And so there were a number of years that we really weren't feeding this pipeline and it was recognized that we were beginning to feel a real gap in this model of training. So in 2007, there was a pilot actually in Florida with 10 associates, and you can see how it's grown over the years. You'll notice in 2009, there was a pause because there was no funding in 2009 after the initial couple of years of experimenting, and then in 2010, we were able to bring on 65 associates and then 64 and a lot of this, we were able to begin to grow the program with the support of our centers that have supported associates to train in their particular categories. So if it's chronic disease or immunizations, they might be funded through that center and then that's where they'll train. They'll train in that capacity. You can see in 2012, we reached a hundred. I will tell you that Dr. Frieden in 2011, when we got to 64, gave me a stretch goal. I remember sitting in the meeting where he said let's get to a hundred, and so we got to a hundred and we were quite pleased and we celebrated that we were

able to cross the line, and it was not easy to get to a hundred, and then he said let's go to 200. And so we are on course now. We had 134 in 2013. We hope to bring in 166 in 2014 and hope to reach the 200 stretch goal if you will by 2015. And that's 200 per class which means that at any given time, we'll have 400 of these young, bright individuals out training in health departments. And one of the things we really encourage are the applications from American Indian and Alaskan Native students, so I hope you all do spread the word about the program because we would love to have more. We have had some American Indian, Alaskan Natives in the program.

This shows you a map of the United States with where the PHAPs are located as of 2012 and 2013, so the classes that are in the field right now. You can see that the gray states do not have any associates, so if you're in any of those states, I really encourage you to apply as a host site because – so the students will be applying to the program to be accepted into the program, and then we make assignments out to the health departments that have applied for them, so we would love to, again, place more in our tribal-serving organizations. We have, as you can see the little box there, 235 total assigned to 36 states, two tribes, and two tribal-serving organizations, and so we'd like to see that grow and especially with the growth of PHAP, we have some opportunity I believe here.

Let me just quickly – a few stories. These are some of the – we had Ryan Sully, and he's a 2012 associate that worked with California Tribal Epi Center in Sacramento, California, and he did things – he worked on an assessment survey which determined that cancer is, of course, one of the highest concerns in the AI/AN community in California, and he worked with stakeholders then to develop a cancer prevention intervention, so his focus was there. Shantell Mora, another 2012 associate, worked with the Eastern Band of Cherokee and assisted with data, compiled data and managed for the first ever 210-page assessment of the tribal community's health, she did a nice assessment there and then was co-creator of an extensive health resource inventory for the tribal community that constitutes the beginning of a tribal health asset mapping process. Our next associate there in 2012, Elena Tomich, Eastern Band of Cherokee, provided ongoing technical assistance to tribal government and community by initiating tribal health improvement process and was involved in several additional projects to promote water quality and sanitation. Amanda Gimsland was in Albuquerque at the Albuquerque Area Indian Health Board and focused on tribal community assessment activities, coordinated in-person – we have a behavioral risk – the BRFSS – the behavioral risk – what's the F again? Factor Surveillance System – I drew a blank there for a second – in tribal community and administered the Youth Risk Behavior Survey as well in New Mexico and Colorado middle high schools, so you can see, they just get involved with a number of different things. And then the last two were not assigned to tribal health departments but did tribal work through their work at the Arizona Department of Health. They were assigned to do some work. In fact, the last one,

Trisha there worked on the Rocky Mountain Spotted Fever outbreak that was a quite serious outbreak. So we really tried to make sure that they have broad experience and it really is applied learning. They're there to learn and they're CDC employees so they report back to CDC, but they have to have an on-site supervisor and they're just a nice connector I believe also between CDC programs and wherever they might be located. So here is your opportunity. It's not too late. You have about nine more days if anyone would like to apply to become a host site, and then that's a competitive process as well.

This is our domestic CDC embedded staff. That's another area that we work on in OSTLTS. I see Dr. Frieden has arrived, so I'll move through here quickly, but we have a number of domestic embedded field staff including the associates I've mentioned and our trainees, but we have others that actually are full-time CDC employees but they are embedded and work in health departments, so you can see, we have last count 646 in the field, so this is a very rich resource and another great connection to all of you. These are the embedded staff that are working with tribes, just to give you an idea of where they are located. One of the things that OSTLTS has been charged to do is to – again, all of the embedded staff are coming from programs, so they're coming from our centers and the programs, the senior leaders that you'll hear from in the round table, they're coming from their programs, but because that's categorical and focused on one area, OSTLTS looks then at all of the field staff, and we are helping to manage, understanding the numbers, where they're embedded, and then we do education for the field staff on areas that they all should be informed about, more of the crosscutting areas. Yesterday, you heard about accreditation, so I won't belabor this, but we are the office that is the touch point for accreditation here at CDC, and you heard from Lisa Corso yesterday on this, so again, I think we can skip through these slides. And then our public health law program, Matthew Penn is the director of that program, and this is a program that provides legal technical assistance to health departments, so you can call upon us and ask us for technical assistance if you have questions that relate to the law, and they've done some work with tribes in the past, so in fact, they've been working on the tribal specimen policy, so they're involved in that. They've been involved with – they put together a public health law 101, the National Indian Health Board Public Health Summit last summer presented this 101 on public health law, and they – I think you heard yesterday about the National Tribal Environmental think tank. They are advisors to that group as well, so some of the things you've already heard about, but please call upon them if you need their help. Actually, I jumped ahead a little bit, so those are some of the things they've worked on. And then we have – I just wanted to give you an idea of the project officers that are supporting tribes across CDC. You can see it's a rather large number here from across the different parts of CDC that support the tribes, and again, OSTLTS, what we do is we think about the project officers as a whole systematically and offer educational opportunities to all of the project officers on behalf of the agency and on behalf of the centers and the list goes on. You can see. Each of these centers, the bolded there, you'll be hearing from the senior leadership

today in the round table, but all of them, as you can see, have project officers that are working with tribes, and we will convene. One of the things that the Tribal Support Unit has done is they will convene all of the project officers working with tribes to better understand common issues that we might have or things that we might make improvements on. I've already mentioned the health official engagement, so I can go through that quickly. They are here as we speak, another one of our missions here. And then another very important subcommittee that we have – Dr. Frieden has an advisory committee to the director called ACD and so the advisory committee to the director has subcommittees, and one of those subcommittees is the State, Tribal, Local, and Territorial subcommittee. I'm the designated federal official for that subcommittee, and it's 15 members on that panel. We meet regularly with them and they make recommendations then that go to the advisory committee to the director, and then, if they are adopted by the ACD, we take those recommendations very seriously and we're, along with our colleagues across CDC, we work to make sure that those recommendations have been implemented, so I want to make sure that you're aware of that subcommittee as well. And then we do a number of things that we invite you to participate in. Chesley Richards will be here later. He is over the office that puts out the morbidity and mortality review of the MMWR, the weekly review, and with that, once a month, we have something called Vital Signs, and this has been going on since Dr. Frieden came to CDC under his leadership. I think it's terrific because it will take one really important public health topic and put out a very good report on not only what the issue is currently and how much it's impacting the health of folks across the United States, but it tells us what we can do and it tells you what you can do regardless of what level, whether you're like state government, tribes, etc., and so what OSTLTS started doing is about a week after the Vital Signs comes out, we convene a teleconference and have folks come together for that so that we can really discuss how do you make this happen, so it's a national call if you will, and we'll discuss whatever the topic is. Actually, the last teleconference was last week, and actually, we focused a lot actually on tribes and we were talking about child restraints for motor vehicle accidents, and that was really a great call. We put out a weekly "Did You Know" so you can subscribe to these. You can also syndicate on your site our "Did You Know"s which brings you timely information on a particular topic of importance to CDC. This shows the syndication – I understand the syndication process is quite easy, which means your website would be refreshed each week with the new information without you needing to do anything. And then we have a reverse communication called "Have You Heard" where we ask that you all please share your stories with us, so this was a nice example, talking about the diabetes talking circles and some of the best practices, and so we want to make sure that we're sharing what's happening in the field.

These are some of the things, looking to the future, so there will be later this week the NIH Tribal Public Health workgroup here in Atlanta. We are still recruiting, just to remind you, we're recruiting three more seats on the TAC, implementing the TAC

engagement plan that Bobby talked about, NIH Public Health Summit listening session and site visit in Billings, Montana. We're excited about that. CDC will have a listening session, and that's March 30th through April 1st. We have representation going to the HHS Regional meetings for the consultations. We want to explore our partnerships with Indian Health Service and the summer TAC, we are still waiting – if anyone would like to host the summer TAC, please let us know. Let me end there, and again, I know Dr. Frieden has arrived, so I want to be respectful of his time. Do we want to go ahead and move to Dr. Frieden?

Chairman Antone: Dr. Frieden will continue on with your update.

Dr. Thomas Frieden: Good morning everyone. Thank you very much for being here. I'm very much looking forward to the time with you and to interchange. I do have some slides to show, but before doing that, I did want to make a few comments to welcome the new TAC members. We have Principal Chief Michell Hicks from the Eastern Band of Cherokee, Chairman Robert Flying Hawk from the Yankton Sioux Tribe, Chairman Herman Honanie from the Hopi Tribe - welcome, Chairman Steve Cadue from the Kickapoo Tribe in Kansas – welcome, Secretary Shawna Gavin from the Confederated Tribes of the Umatilla – okay, sorry, thank you, welcome – represented by Mr. Tim Gilbert, that would be you, great. Council Member Patricia Quisno from Fort Belknap – welcome. Council Member Leslie Sampson, Sr. from the Noorvik Native Community, and Council Member Andy Joseph, Jr. from the Confederated Tribes of the Colville Reservation who is I think calling in on the phone, so we will circulate the slides later, and I want to thank our chair, Councilman Chester Antone from the Tohono Nation for your leadership of the TAC. I really appreciate it personally and organizationally, thank you. I also want to thank the TAC members who are continuing to serve, President Alicia Reft from the Native village of Karluk, represented by Dr. Jay Butler. Lieutenant Governor Jefferson Keel from the Chickasaw Nation, authorized representative is Ms. Lisa Pivec attending – welcome back, and Vice President Rex Lee Jim from the Navajo Nation, authorized representative is Ms. Ramona Antone-Nez, also attending. And Director Cathy Abramson from the Sault Ste. Marie tribe of the Chippewa Indians and, of course, Chairman Antone. I want to thank you all for your service, both to your communities and for engaging with us so that we can try to make our programs continuously more responsive to your needs, to your direction, to your perspectives. Thank you. And I really look forward to the day. I'm sorry that I won't be able to be with you personally in the afternoon, but I will be following closely and get all of the details of the information that you present in your testimony this afternoon.

I did want to give just a little bit of information before we have a discussion, first that funding for American Indian and Alaskan Native programs is really aligned with disease-specific areas. Our budget is determined by Congress. Congress puts it into nearly 200 different budget lines. We are prohibited from moving it between one budget line

and another. For Indian Country, these programs are pretty well aligned with where the greatest burden of disease is in terms of chronic disease prevention being the dominant cause but also the need for public health capacity building, infectious disease control, environmental health, and other areas. I will comment that from 2012 to 2013, CDC's budget went down quite substantially, went down by almost 10%. We got essentially a double sequester. Despite that, we were able to slightly increase the amount of money going into Indian Country, so we've tried to protect the front lines and we've tried to protect funding to American Indian and Alaskan Native populations and contractors throughout the process. In our 2014 budget, we're seeing a level to 2012, so we'll continue to do whatever we can to prioritize funding to the front lines and support to front line programs. We also, in 2013, produced a report on health disparities and inequalities where we looked at different racial, ethnic, geographic, socioeconomic groups and some of the data that I will show you comes from that report. We have that available for you if you would like it. It's available electronically. In some of our prior meetings, I've heard loud and clear that you'd like more information about the health of your communities, and while sometimes sample size makes that difficult for individual communities, at least we can aggregate, although that's not ideal, to provide some information that may be of use and importance.

Of all of the statistics in this report, which is a big thick report, the one that brings tears to my eyes is the next one which shows the rate of suicide by different race ethnicities, particularly in young American Indians and Alaskan Natives and I think this is both a terrible tragedy in and of itself and it also represents a context that is very challenging and very important that we do whatever we can to address. Suicide is such an awful tragedy, especially in a young adult. And I think some of this reflects the multiple challenges that individuals face in their lives, and some of this reflects their view of the future and what kind of hope may be present for the future. But whatever we can do to address this, we're certainly willing to. We also see very high rates of motor vehicle-related deaths, and I know we've had some programs that have been quite successful at reducing some of the risk factors for motor vehicle crashes in Indian Country. They're not implemented with the scale we'd like, but where they've been implemented, they've made a big difference. We also see very high rates of drug-induced deaths, and we have seen over the past decade a big increase in prescription drug abuse deaths in the US generally. We also see a higher rate of smoking in both adults and youth and high preterm birth rates, not as high as the African American but higher than white, Hispanic, and Asian. And similarly, the second highest rates of homicide of any group. Also, the second highest rates of binge drinking behind white Americans at this point. With all of the kind of bad news on health challenges, I'd like to really focus on what is something that we can make a big difference on, that if we focus on it, we can have very substantial progress. And for this, I think cardiovascular health, heart disease and stroke, is really crucial. Heart disease and stroke kill more people than anyone else. It kills people young. It's not just older people. It kills people preventively, so we know

what to do, and it doesn't just kill people, it also results in strokes and heart attacks and disabilities. Across the country, more than two million people a year, every year, have heart attacks and strokes. Over 800,000 die. The medical costs and societal costs are enormous. And there's actually quite a bit that we can do to reduce cardiovascular events. Perhaps the single-most important thing we can do is to control blood pressure. Blood pressure control is probably the leading preventable or treatable risk factor in our society. Now, there are certain things that can be done to reduce blood pressure from lifestyle approaches. For example, getting more physical activity, reducing sodium intake, having a healthier diet, reducing weight. All of these things will reduce blood pressure, but the sad fact is that in our modern world, even if we do all those things, most people are going to get high blood pressure by the time they're over 60. So we need also to have good treatment of high blood pressure. The good news is that there are lots of medicines that work very well that don't have to be expensive that can be taken once a day that are very safe that don't have bad side effects. So we need to both prevent high blood pressure, but we also need to treat it better. I was recently in the Minneapolis area because Minneapolis, which has a large American Indian population – Minneapolis as a community has taken blood pressure control to heart, and they said we're going to get this right. And their blood pressure control rate is substantially higher than the rest of the country. I'm afraid that the American Indian population continues to not have the same benefits as the rest of the community there and they're working on that to try to improve it. They're very aware of that disparity, but the point is that blood pressure control is something that we can substantially improve by working with communities and healthcare facilities. This is where we are generally. About 25% of American Indians, Alaskan Natives have high blood pressure. Nationally, in the US, there are 67 million people with high blood pressure of whom 53 million are aware of it. Now, this was something of a surprise to me because I thought most people who have high blood pressure would know it but maybe not be on treatment or not be on adequate treatment. What the folks in Minneapolis-St. Paul did was they greatly increased that proportion. So almost 95% of the people in Minneapolis-St. Paul with high blood pressure know they have it. So one thing we need to do is increase knowledge of high blood pressure, and one thing that we've found is that healthcare providers may be part of the problem. Some of the best healthcare providers in the country have told us that when they looked at their own data carefully, they realized that about 30% of all of their patients with high blood pressure had never been told they had high blood pressure, didn't have a diagnosis in the medical record, and weren't on treatment for it. So there's a lot we can do to improve awareness. And then most people who are aware are on treatment, but unfortunately, a large proportion of those who are on treatment are not on adequate treatment, meaning that their blood pressure is not adequately controlled and they remain at a higher than necessary risk of heart attack and stroke and other serious health complications. So our Million Hearts program has the goal of preventing a million heart attacks and strokes by 2017 through community prevention which will reduce the need for treatment. That includes tobacco

control, sodium reduction, and trans fat elimination. Artificial trans fat is a commercially industrially produced product that is solid at room temperature. It's also solid at body temperature in the arteries to your heart. And the Food and Drug Administration has recently issued their view for comment that there is no reason for it to be in the food supply and that it is not generally recognized as safe. In terms of the clinical prevention, healthcare facilities who focus on the ABCS, that's aspirin, blood pressure, cholesterol, and smoking cessation, those four things can save more lives than anything else in the healthcare system. To use health information technology to empower doctors, healthcare systems, and patients and to have clinical innovations, especially team-based care with community volunteers, nurses, nursing assistants, office assistants, nurse practitioners, physician assistants, pharmacists all involved in the care of patients. And we know that that kind of team-based care gives much better results.

Million Hearts will mean nationally across the US 4 million fewer people smoking and 10 million more people with their blood pressure controlled. We do have a variety of programs to promote in partnership Tribal public health. I'll mention just a few of these here. Judy mentioned some in her presentation. One is strategies to reduce motor vehicle injuries, and as I mentioned, I've shown this in previous years, but the results are really quite encouraging. We saw doubling of the rate of seatbelt use, substantial increases in the use of car seats, reduction in unsafe driving. And it was really done as a partnership led by Tribal leaders, and I was privileged to hear some descriptions of how that worked in different communities. It was really encouraging to know that each community has strengths and was enlisting those strengths and addressing this serious problem. Tribal tobacco control program to reduce smoking and tobacco use. The TIPS campaign featured in this past year two American Indian and Alaskan Native individuals talking about their story and the views of those I hope are being widely seen and shared in Indian Country. Unfortunately, Nathan Moose died this past year as did Terry Hall, both of them in their early 50s. Nathan never smoked. He was exposed to tobacco through his work in a casino and developed COPD and died from it. Terry Hall began picking tobacco as a teenager, smoked for much of her life, got cancer in her 40s, and died in her 50s. And we were really very privileged to work with very courageous individuals who've come forward for the TIPS campaign to tell their story in the hopes that it will help other people not have to go through what they went through. It wasn't easy for them to tell their story, involved painful discussion, and you may remember the gentleman here talking about how to tell your grandkids that you won't be around for them. Very, very powerful messages. We also have a Native diabetes wellness program with traditional foods. So much of the tradition is so healthy and yet difficult to get back to. Difficult in the face of our modern era for all of us in every community to go back to some of the healthier traditions that we've had. I mentioned sodium reduction. Years ago, there was a wonderful study that was done in 32 countries around the world called Intersalt, and it looked at sodium consumption in 32 countries and in many communities. There were four communities, three of them

indigenous communities, not in this country but in other parts of the world, where the sodium consumption was on the order of 500 mg per day. Ours is about 3500 mg per day. There was no sodium shortage in those communities. There was no ill health effects to those individuals. They were also leading a very active lifestyle, physically active. There was no – zero – high blood pressure in those communities. Now, whether that's because the 500 mg a day of sodium or something else, no one can prove, but we know that sodium and blood pressure are tightly correlated. And it's really a striking result that not only was there no high blood pressure, but teenagers had a blood pressure of around 90/60 and 60-year-olds had a blood pressure of around 90/60, so not only was there no hypertension, but there was no age-related increase in blood pressure. And to me, that really makes a very powerful point, that many of the traditional ways of eating and being active had us not have aging in the ways that we currently assume is a normal part of the aging process. It's not a normal part of the aging process. It's a common part of the aging process. It's a near-universal part of the aging process, but it's not normal, and I think that study gives that as an example. The Get Yourself Tested campaign across Indian Country. Flu activities. Of course, we have a very long and very productive partnership on vaccination programs generally and reducing vaccine coverage disparities and working in partnership with the Indian Health Service and the SAMHSA, the Substance Abuse and Mental Health Services Administration. We have a simple goal, which is to work in partnership nation to nation to improve the health of all populations and eliminate health disparities, to ensure that American Indian and Alaskan Native communities receive public health services that keep them safe and healthy and to collaborate, to develop programs and activities that target and address the needs of American Indians and Alaskan Natives. And I wanted to leave plenty of time to listen and discuss and answer any questions that I can answer that you have, so I'll just end with a question which is that how can we working together catalyze health improvements across Indian Country, and I'm here with you and looking forward to interacting with you.

Councilman Antone:TAC members, are there anyone who wishes to address Dr. Frieden? Mr. Honanie.

Chairman Honanie: Good morning, Chairman Honanie, Hopi. You had a slide up there that spoke to heart health and strokes and the cost, and I take it that this cost is reflective of nationwide incidences and so forth. I was wondering if there's any data that can be isolated to just the Native American population across the nation and more so if there could be efforts respectively within our own areas and communities to isolate those numbers as well, to bring up what those numbers are in terms of cost of heart disease, stroke, and related illnesses because I think that when one shares that with a community, they begin to realize and understand what it costs for an individual to look the other way and not take control or responsibility of their health. I remember one gentleman did, that a service director did that years and years ago, and I was really

startled and really kind of taken by the numbers that he showed up on the screen like this. And this was some 25 years ago, and since then, I've never seen anything like that presented by public health, but we deal with numbers. We draw out numbers in such amount that it doesn't make any difference to anybody, so if we could be able to have numbers applied to our respective communities, I think that would make some difference. And people will look at that and – because we're such a small community, we know a lot of people who may have certain conditions because their family, their relatives, and clan and so forth, and I could turn around and say to my relative – say you're not taking care of yourself and this is what you're costing us and this money could be well spent on something else. You know, this kind of thing, so if we could get that kind of effort going and really be able to show what it's costing us in terms of cost because of disease and illnesses. I think that would help us to really better understand that plus maybe be an incentive to better control and take responsibility of our individual health. That's all, thank you.

Dr. Frieden: Thank you, very much. We will definitely follow up on that. We'll get our best estimate. If we don't have actual concrete data, we'll give you our best estimate of cost across Indian country and perhaps a way of estimating those per thousand or five thousand or 10,000 people what you might see. What some community leaders have told me in various communities is the other thing that makes a big impact on people is if you simply ask. Do you know of people who've had a heart attack and stroke at a relatively young age and do you realize that many of those heart attacks and strokes may well have been preventable through simple things that don't have to cost money. But we will definitely follow up about the cost issue. Thank you for that suggestion.

Councilman Antone: Chairman Cadue.

Chairman Steve Cadue: Morning Dr. Frieden. I wish to thank you for the welcome that you gave everyone here. I was recognized as an at-large delegate in your presentation. Very quickly, I've seen what I sense is your heart, your commitment. Very quickly, I think I've seen that. In your opening presentation, you talked about the high blood pressure and the diseases and you've labeled them, which they are, they're killers. We're talking about these diseases being killers. In this case, as to why we're here, killers of Indian people. I don't know what health officials call epidemic, but from what I see out in Indian country, these diseases, especially diabetes, heart problems, are epidemic. I think more federal officials, especially our federal government, should look at it that way also because in our Indian communities, the size of our populations, when we lose loved ones, none of us, whether it be Indian or otherwise – it's sad when we lose a loved one, be it family, friends, what have you. But when we in Indian country lose our people, we're losing our future. Per capita, these losses heavily, heavily impact our Indian communities. In fact, we're losing experienced tribal leaders. That's another issue that I see. I wish that some of those tribal leaders – and I think that for whatever

reason, had they had better healthcare or took care of themselves, they would be at the council table with me with the Kickapoo Nation. I think those things were preventable. We lost a tremendous treasure when we lose those people. Finally, you've asked for solutions, I don't know your career experiences and I don't know how well you know Indian Country and the government, Tribal government, the Sovereign government. I know from where I stand as Tribal Chairman, I think health priority and taking care of the health needs is our priority. But let me leave you with this. Good, better, indifferent, we as tribal leaders, we try to do our best across the board with very limited resources, not just on health but across the board. But I think that if the Indian Health Service and the CDC and other agencies could get a better understanding of the tribal government practices, that would be very helpful to delivering [inaudible] healthcare. Because I will admit, and what I'm saying is that tribal government – and I'm here with fellow tribal leaders – we can do a better job working with the health agencies. Tribal government controls, directs as it should be. That's what sovereignty is. The tribal government and its delivery systems and what it can do to help Indian healthcare I think is hardly being tapped as it should be, but we have to step up as tribal leaders also. But the Indian Health Service, federal government as in President Obama, has got to understand the role of tribal government I think better than it does. I think you're missing a powerful asset, a powerful resource to improve in Indian healthcare by not understanding tribal government and its practice. Thank you, Dr. Frieden.

Dr. Frieden: Thank you very much for those comments. They're very important and your comments on the tragedies and the losses remind me of a statement that one of my predecessors, Bill Foege, has made that I think is very powerful, that we in public health are at our best when we see and help others see the faces and the lives behind the numbers. We're very number focused, but behind each of those numbers is a tragedy, a life, and I think the point that you make is even broader, that it's not only about the individual and their family, it's about the community and the nations that are being robbed of the potential. I certainly agree with you about the importance of tribal government, and I would maybe mention two areas in which we can think further in the coming year about what more we can do. When we have specific programs in health, we have specific interventions that we undertake, but we're also changing a broader context, a broader way of looking at health, and I'll mention – because there have been positive changes in many communities – tobacco and alcohol as an example. In tobacco, in my lifetime, I remember when it was very common for people to come over to other people's house and to offer a cigarette as a mark of friendship. And now, if you went over to someone's house, you might say do you mind if I smoke, but more likely, you wouldn't even say that because it would be so impolite. That has happened as we've had Smoke Free Air Act, making public spaces smoke free, but what's developed is a change in the social norm. In the same way, again, within my lifetime, people would say when someone was leaving their house, would you like a drink for the road, would you like one for the road. Now, people would say friends don't let friends drink and

drive. Now, both of those changes required both legal and regulatory actions but also social changes. The legal changes made the social changes happen. The social changes allowed the legal changes to happen. So as leaders, I think we have the ability – you have the ability – to begin addressing some of the social norms, whether it's on tobacco or alcohol or physical activity or nutrition or other areas that are going to affect health in ways that are even broader and more effective sometimes than healthcare. The second area I would hope we would think about some has to do with the structure of the healthcare delivery system and the use of community health workers. As you may well know, some of the first ever use of community health workers in this country was in Indian country in some tuberculosis outreach projects that occurred in Alaska and the Midwest and elsewhere. And we've learned a lot of lessons about community health workers. In some circumstances, they've been very effective. In others, much less so. And some of the things that make a big difference is that they're fully integrated with the healthcare system rather than independent entities, that they're well trained, well supervised, and well supported. And as we look at the healthcare system overall in this country, I predict that we will see an increasing use of team-based care where nurses will do more than they're currently doing, nurse practitioners, physician assistants, pharmacists will do more than they're currently doing, and we will have an increased use of community health workers. That has to be done in a way that's structured, supervised, efficient but in Indian Country, you may not have some of the restrictions that may exist in some states of the US on having that kind of team-based approach. I think this is something that we can certainly explore in the coming months and years, and I'd certainly agree with you that making sure that as a nation-to-nation interaction, we have every opportunity to have tribal governments take a leadership role in improving health will give us the best possibility of progress and success. Thank you.

Councilman Antone: I will recognize Mr. Gilbert and then Cathy Abramson and then Mr. Jim.

Dr. Frieden: I'll hold my comments until after these three comments.

Mr. Tim Gilbert: Thank you, Mr. Chair. Good morning, Dr. Frieden. Thank you for being here and taking the time to share some information with us. We know that we're a smaller segment proportionately of the whole population you're charged to serve, but we appreciate you took the time to be here. I'm Tim Gilbert, I'm not Shawna Gavin, representing the Portland area which is a three-state area with over 40 tribes represented. I just have a couple of quick questions for you. On wait, wait, don't tell me – you stated that – I'm just kidding. You did very well on that by the way. I was really curious about your comment, your slide on suicide prevention. We have the Yellowhawk Tribal Health Center which serves the Confederated Tribes of the Umatilla Indian Reservation has had Garrett Lee Smith Award, a SAMSHA award for suicide prevention, and I don't have a specific question about what CDC is doing in that area

but the question that came to mind was whether you or CDC hears the discussion that might happen from the Tribal Advisory Group that consults with SAMSHA, and we learned about a different advisory group, the STAC, the advisory group that consults with Secretary Sebelius. I think there may be another one in there somewhere, but we pursued that SAMSHA award and it's been a great asset to us. The SAMSHA world is a different animal when it comes to grant management than CDC is, and I just was curious whether or not there is cross talk between the different advisory groups in the HHS agencies.

Dr. Frieden: Absolutely, we do learn whatever lessons we can from the other HHS agencies and work in collaboration and partnership to the greatest extent possible, and the area of suicide prevention is a very important one and it's one where we have some knowledge but need more on what more we can do to reduce suicide attempts and suicide successes or completions of suicides, because it's just such a terrible phenomenon, and to the extent that we can learn from different communities on what's working, that's very important and we'd be very interested in both learning and sharing any positive lessons on this topic.

Councilman Antone: Ms. Abramson.

Cathy Abramson: Good morning, Dr. Frieden. Thank you. It's nice to see you. I just want to say way to work together to catalyze health improvements across Indian Country is one thing – and this is not to blame – this is just a matter of fact. Not long ago, just a few hundred years ago, this was all Indian Country. And it's just a fact, and our lives were changed because we were moved, land was – you know, the amount of land that we lived on and how we lived was changed immensely. When you think of Indian Country now, there's different blots on the map whereas before – so – and most people think of Indian Country in that way now. So that, again, wasn't that long ago. What we're finding is going back to our ways is the ways that will bring us back to being healthy, so there is a big difference than most other people that are in the United States, you know, as opposed to the Finnish people, the other people that came over and my husband's a Finlander by the way. There's a lot of similarities, too. But so our way of life was interrupted, and so we want to get back to that and a lot of who we are – you have a lot of confused people and in just the way we lived, we had our clan system and people knew what clans they belonged to and what their jobs were, what their purpose were in life, and I think – and with that, a lot of our people were made to feel less than human, so to come back from that and grow stronger, healthier – mentally, physically, spiritually – it's going to take a while. It took a while to get there. It will take a while to come back. And I think just understanding that it's going to take a while to come back. That's how we'll be able to work together. Two questions I do have is can the CDC support Tribal Epi Centers as they look at cost benefit analysis of different types of

illness and then the next question is can CDC provide support to Tribal Epi Centers by giving more access to the data that epi centers need? So those are two questions.

Dr. Frieden: Thank you very much for your comments and I would just reiterate that whatever we can do to shorten the amount of time it takes to get back to a healthier community, we're willing to do. On access to data, we're totally committed. We will do whatever we can. I think you have a – Judy, I heard you say something about Chesley Richards. Will he be here later?

Dr. Monroe: Yes, we've got a round table with senior leadership just in a few minutes.

Dr. Frieden: Okay, so we absolutely will make data available. It doesn't always exist to the extent that we would like, but whatever's there, we'll make available. In terms of cost benefit, this is an area that we are also trying to strengthen our capacities in but we're certainly very happy to learn with you and to share resources with you. And one of the things that we have been working on is some standardized ways of doing this that may make it easier to be done, so we'd be very happy within our policy office to provide any partnership in that area.

Councilman Antone: Because of time, I want to recognize Rex Lee Jim and then we'll end this session with Rex and then we'll move on to the next. Thank you.

Vice President Rex Lee Jim: Thank you, Mr. Chair, and tribal leaders. Dr. Frieden, thank you for allowing us. First of all, I'd like to say thank you for allowing your senior leadership to be a part of this whole process. We appreciate it and we ask for your support to continue that. The other is we also would like to ask of you to invite senior leadership from other agencies and departments. For example, SAMHSA should be here to be a part of this discussion and to listen to it so we can begin to find ways to pool our resources together across the various departments and programs to address some of the critical issues in Indian Country, so just to catalyze health improvement across Indian Country. That way, we might maximize our limited resources. I guess for us in Indian Country, the question is how can we make a dent in health disparity. For example, funding allocation is only at 2% for injury prevention and yet, on the Navajo Nation, that's the number one contributor to mortality rate for Navajo. That's the highest, so how can funding be increased to injury prevention – 2% - and that brings up the whole question of distribution – funding distribution. It seems to me, we're throwing a penny here and a penny there and a penny there and we hardly – the move is very slow, so how can we target that funding to specific programs – like for the Navajo Nation, it would be increased funding to injury prevention because that's the highest mortality – contributes to the highest mortality rate so how – if we do that, then we can probably prevent – put a dent in that. Yesterday, we also learned that – I think it was Alaska – has the highest colorectal cancer, so if we could put more money into that in

that area. So how do we work with Indian Country in ways where we invest the most in the cause of the number one illness in someone, so I think we need to really look at that. The second leading cause of death in Navajo is cancer and the third is heart disease. So the Navajo Nation is talking about – well, we’re working on a medical school and also working with the science hospital there, the medical center, to create a cancer research institute, to make it a teaching hospital. So how can CDC help in that work? Whether it’s contributing human resources and expertise or putting some funding into it. So we’re interested in that. The other is yesterday, ATSDR presented and shared the work of the think tank, and it was mentioned that members of that think tank thought that work with them is considered – well, they consider that consultation and tribal leadership would disagree with that because the outcome of that work needs to be shared with tribal leadership in order to be considered consultation. So we need to find a way to make that formal because the work of the think tank is very important and it should be considered part of consultation but the question is how do we formalize it so that we all know that that work is consultation and that the outcome of that work is shared with and blessed by the tribal leadership. Thank you.

Councilman Antone: Thank you, Mr. Jim.

Dr. Frieden: Thank you very much, and I wish I could solve all the problems, but we can’t. I wish we had more resources, but we don’t. We’re reliant on Congress. But one thing that we can do is focus as well as we can within areas and that would not be our focus. It would be our provision of a menu of things for each community to decide what to focus on. So we have an entity called the Community Guide to Preventive Services where we look at what works in community prevention and divide things into three groups – recommended because it works, not recommended because it doesn’t work, and insufficient evidence it might work and you might want to try that and study it so we can learn if it works or not. In the area of injury prevention, we know there are interventions that work to reduce motor vehicle-related injuries. We know there are interventions that work to reduce alcohol use and, therefore, injuries. We believe there are interventions that work to reduce drug overdoses, which are considered injuries. And we’re scaling up in each of these three areas, so I would say for any community, look at the list of recommended things and then can we focus in one area, and if we don’t have financial resources, can we provide as much technical collaboration as possible. In terms of cancer and heart disease, I think we have, of course, a breast and cervical and colon cancer program, and Dr. Ursula Bauer is here and will be part of the dialogue. Dr. Bauer has spent a significant amount of time in recent years in different American Indian and Alaskan Native communities and has brought back very important perspectives from the time she spent there. So we have a cancer program. We also have a heart disease prevention program and I would go back to the issue of community health workers and trying – it’s a real win, win, win, win because if you involve community health workers in the care of patients, you can improve quality

because they can apply standardized protocols and algorithms with more fidelity than a busy doctor will be able to do in his or her own practice, so that's one win, so you get better quality there. It's a win because you're able to get better access because the community health worker will be closer to where the patient and the community is, so that's a second win. It's a win because you'll reduce the cost of care. To have a doctor do something is much more expensive than to have a community healthcare worker do it and yet, the community healthcare worker may do a better job for many of the tasks, so that's a third win. And the fourth win is you'll have employment so that at a constant level of healthcare spending, you'll employ more people from within the community. So I would just highlight this as an area to follow up on. I'm not familiar with the ATSDR issue that you raised, but I will follow up and am certainly committed to anything we do. We have a basic ethos which is that it has to be the highest quality scientific data openly and objectively derived and then openly shared. So I will follow up on that issue specifically. I'll be here for a few minutes in your break to chat informally with people, but I really want to thank you for spending your time for what you do in your communities and for coming here, and I'll look forward to getting a very detailed description of the remainder of the deliberations here today. Thank you very much.

Councilman Antone: Thank you, Dr. Frieden, and before I let you go, I would just like to remind you that we have a Rocky Mountain Spotted Fever outbreak in Arizona tribes and also another thing that I want to remind you or to let you know is that bedbugs bite that leads to scratching and they lead to sores and among diabetics, that's a slow healing process if at all. Just to leave you with that, I had to jump in here but thank you. And for the TAC membership, we will be meeting down by the staircase for a photo op with Dr. Frieden out here in the lobby. Thank you. Oh, and after the photo op, we'll come right back because we have a very important [end of this session].

Councilman Antone: Okay everybody, we're ready to begin with the round table discussion with CDC senior leadership. Will everybody take their places please? This part of the agenda, we will be giving the CDC senior leadership – ask that you give up to a three-minute presentation and we'll go through all the presentations first and then that way, hopefully, we'll have enough time for question and answer. So, again, we'll allow two to three minutes per person and then after that, we'll have further question and answer session. Thank you, and I'll begin with Ursula Bauer.

Dr. Ursula Bauer: Good morning, everyone. Nice to be back with you today. My name is Ursula Bauer. I'm the director of the National Center for Chronic Disease Prevention and Health Promotion. I had a brief opportunity yesterday afternoon to describe our center to you. We address the leading causes of death - heart disease, cancer, stroke, diabetes - and the leading risk factors – tobacco, poor diet, physical inactivity, alcohol use. We have an oral health program and a reproductive health program, and I described yesterday a community health focus that we have as well in the center, so

really a wide scope within the National Center for Chronic Disease Prevention and Health Promotion and we do a tremendous amount of work in Indian Country. We have a budget of about a billion dollars. As Dr. Frieden says, that's fluctuated over time. We do make sure that we dedicate 2% of our dollars that go out the door to Indian Country. We look at the population overall and make sure that we're investing in terms of per capita, not necessarily in terms of burden, and we do recognize the huge burden that chronic diseases bring to bear on Indian Country. I mentioned yesterday a number of forthcoming grant opportunities for community health for diabetes and heart disease and for disparities work. I want to take my remaining minute this morning and describe the way that we work across our broad portfolio within the center. We have four key areas of focus across our programs. These include epidemiology and surveillance, which we've heard a lot about the need for data in Indian Country and the tribal epi centers which we will work with Dr. Frieden in terms of finding opportunities to better support the work of the epi centers. The second area is what we call environmental approaches, and these are what Dr. Frieden described as those social norm changing interventions. The laws, policies, regulations that change the way people think about tobacco use, about alcohol use, that makes opportunities for physical activity available, that makes sure that healthy foods are available, minimizes access to the unhealthy foods, so changing the environment so that people actually have the wherewithal to make healthy choices. The third area is working with health systems around delivery of clinical and other preventive services, building the demand for those services as well as ensuring that when people do come into the healthcare system, those services are effectively addressed. And the last area we call community clinical linkages, and this gets at that team-based care that Dr. Frieden was talking about and community health workers and really looks at how we can ensure that communities are supporting the behaviors and helping to manage the conditions that are being diagnosed and treated within the healthcare system. So for so many of the conditions in our portfolio – diabetes, heart disease, arthritis, and on and on – there's so much that an individual can do if they have the support in the community to better manage those diseases, delay or avert progression, avoid complications. But you need that support and that structure in the community to be able to do that effectively, so that fourth area really addresses that. So that's our center in a nutshell, and I look forward to the discussion.

Councilman Antone: Thank you, Ursula. The next person we have will be Katherine Lyon-Daniel, associate director for communication.

Katherine Lyon-Daniel: Good morning. Thank you, and welcome to all of you. Thank you for coming here. In the office of communication at CDC, we strive to extend our CDC's health impact through communication which is accessible to everyone which is strategic using the latest in communication research and technologies and which preserves – always preserves our scientific integrity and credibility with the public. I have some handouts of what my particular office does, but more importantly, throughout

CDC, there are offices of communication which do fantastic work, and in the office of the director, we do often the coordinating and then the technical things like broadcast services and graphics and media that don't happen within those centers. Most importantly for you, what we want to do is to help you do what you need to do to communicate with the people that you need to reach your people. We've worked with STLTS. We have resources online in a communication resource center which I can get to you which provides materials that we have come up with to date, templates, fact sheets, podcasts, videos, press releases, web template designs, which is all those sorts of things, but what it doesn't have yet is what you want from us. So that would be my thing. I'd like to say in my three minutes today is I would like to know more from you now or in the future what else we can do to make your jobs easier in communicating about health. That's the most important thing we can do, and I look forward to hearing from you. Thanks.

Councilman Antone: Thank you, Katherine. And we'll go to Stephanie Dulin, Deputy Director, National Center on Birth Defects and Developmental Disabilities.

Stephanie Dulin: Good morning everyone. Pleased to be with you and tell you about our center. The National Center on Birth Defects and Developmental Disabilities contains three divisions. We have the Division of Birth Defects and Developmental Disabilities which houses our fetal alcohol syndrome and fetal alcohol syndrome spectrum disorders program work as well as much of our surveillance efforts. We also have the Division of Human Development and Disability, and that particular division focuses on disability through life span, so while our name says birth defects and developmental disabilities, we go through birth all the way through the end of life to ensure that everyone has a healthy and happy life and life outcome. We have our third division which is the Division of Blood Disorders which focuses on hemophilia, sickle cell disease, and other rare blood disorders. What we primarily do in our work in Indian Country has been related to the work that you'll hear more about this afternoon from our two subject matter experts, Catherine Hutsell and her colleague. They'll tell you about the work that we're doing in alcohol screening and brief intervention as well as our work with the Choices program, which is a behavioral intervention program to help protect mothers during their pregnancy to avoid alcohol, tobacco, and known toxins that have poor birth outcomes. So we try to make an impact as early as possible. We also try to have secondary prevention work, and that's through our Division of Human Development and Disability through many of our partners. You may have worked with the MPT Coalition who is funded directly through CDC. They've done work on several Tribal Nations with amputees as a result of limb loss to diabetes and working with those individuals to help them improve their diets and their exercise and to go on living after an amputation. We also worked with the Reeves Foundation that has worked on Navajo Nation with the Paralysis Resource Center in working with trying to get good health messages out to that particular population. We're a small center. I think I've

mentioned that we have a small budget of 122 million dollars, so not much but we do have big hearts and a lot of folks that are willing to help in whatever capacity that we can. So, again, I look forward to the discussion and am happy to be able to visit with you all today, so thank you for the time.

Councilman Antone: Thank you, Stephanie. Next we'll go to Corrine Graffunder, Acting Associate Director for Policy, Office of Associate Director for Policy.

Corrine Graffunder: Good morning, thank you very much. I also welcome you here and as one of the other offices at the OD level, the Office of the Associate Director for Policy also has as part of its mission to really advance our health outcomes in the interest of the agency, and we do that by looking at policy and policy levers. We also do that by right now, very much focused on the transforming health system and how we understand the opportunities that exist within that health system transformation for public health and population health and then lastly, we also have interest in how we work with and think about engaging other sectors that are non-health sectors in, again, advancing our interest in population health, so very quickly, the way we do that structurally then is we have three offices. One of the offices is our Policy Research Analysis and Development Office, and that's really a crosscutting analytic arm within our office that really does support policy analysis as well as very importantly, a lot of the work that we're doing right now is around economic and budgetary analysis and how we think about and help understand or help translate what we know from the standpoint of interventions that work around health impact to then looking at can we better understand the economic and budgetary impact of those interventions on a particular health system, whether that system be CMS, whether it be private or public payer systems. Another office that we have is then an Office of Health System Collaboration. That office has two main areas of interest or focus. One is the health system transformation that I was just talking about, looking at methodologies around integrating data, working with our colleagues in CMS, etc. We also then have a separate part of that office that really is focused on maintaining situational intelligence if you will around the health reform, the evolution of health reform and the ACA and the ongoing implications of ACA, so that's another area that we have a group of people that stay involved in. Lastly, we have the Office of the National Prevention Strategy and that office supports the non-health sector engagement so that National Prevention Council includes 20 federal agencies and those federal agencies are charged with really advancing prevention in a number of different ways. So I think I'll stop there and if you have questions, but that's our overview.

Councilman Antone: Thank you. Next, we have Captain Thomas Hennessy, Arctic Investigations Program.

CAPT Thomas Hennessy: Hi, good morning. I'm here representing the National Center for Emerging and Zoonotic Infectious Diseases, one of the three infectious disease centers at CDC, and I'm here representing Dr. Beth Bell who is our director. Our center has a wide range of activities and subject matter expertise, but I think the areas that affect Indian Country the most are related to infections that are acquired through food, through water, and through contact with animal or insect vectors. We don't do a great deal in terms of direct programmatic support but provides lots of technical expertise, and many of you at the table are familiar with programs in Indian Country, and three of the areas that have been most active in the last year have to do with the collaboration around Hantavirus education with the Navajo Nation. Also work on Rocky Mountain Spotted Fever through the Intertribal Council of Arizona and then also through the program that I'm the director of in Anchorage, Alaska, the Arctic Investigations Program which is directed at infectious disease threats among people in the Arctic and subarctic. I'd be happy to take any questions when we come around to that. Thank you.

Councilman Antone: Thank you, Captain Hennessy. Next, I'll go to – I don't know how to say your name. Robin Ikeda?

Dr. Robin Ikeda: Good morning and welcome. I'm Robin Ikeda. I'm Deputy Director for Noncommunicable Disease here at CDC. I work with the four noncommunicable disease centers – birth defects, environmental health, injury prevention, and chronic disease. And our office primarily supports those four centers in achieving their mission but we also in my office work to link and connect those centers together around topics that cross all of them, whether it's alcohol or mental health, disability, global noncommunicable disease, and then also help the centers extend their reach, both across CDC and then externally as well. Thank you.

Councilman Antone: Thank you. Now we'll go to Rima Khabbaz, Office of Infectious Diseases.

Dr. Rima Khabbaz: Yeah, good morning. I'm Rima Khabbaz. I'm the Deputy Director for Infectious Diseases and Director of the Office of Infectious Diseases, and I'd like to add my welcome, too, and apologies that I couldn't make the social yesterday. I tried to but somehow couldn't get to it to chat with you some more. So my office houses the three infectious disease centers. You've already heard from Captain Hennessy of the National Center for Emerging and Zoonotic Infectious Diseases, and you'll hear from Admiral Schuchat about the National Center for Immunization and Respiratory Diseases and from Dr. Mermin about the work of the National Center for HIV, Hepatitis, STD, and TB Prevention. The only thing I would add is across the three centers, we have an interest and a high priority in what we call the Advanced Molecular Detection. I would mention it because it's I think relevant to all of public health and touches you in terms of the public health plans which is introducing the latest of molecular technologies to

improve our laboratories and their ability to detect and respond to infectious diseases, so we are very excited about that our budget this year has a little bit of resources to start doing that, both here at CDC and then also throughout the enterprise. The other two things that I will mention that are relevant to Dr. Beth Bell [inaudible] who is our priorities and antimicrobial resistance, specifically antibiotic resistance, is a huge problem everywhere, and I think it touches you in terms of healthcare delivery and it's prevalent and important and getting worse, so we have as a priority dealing with it and also healthcare-associated infections as an important priority. Thank you.

Councilman Antone: Thank you. Ali Khan, Office of Public Health Preparedness and Response.

Dr. Ali Khan: Good morning, Mr. Chairman, and thank you very much. We have the honor in the Office of Public Health Preparedness and Response to support CDC in our efforts at the state, local, tribal, and territorial level to make sure that our communities are protected against all public health threats 24/7, no matter what their nature, whether they be pandemics, whether they be disasters, whether they be terrorism, or the routine public health threats of every day. The CDC maintains a comprehensive health security program that includes a granting program to state and local partners. It includes a regulation of all labs that have the most dangerous pathogens in the world. It includes a Strategic National Stockpile, and it includes an emergency management program, and I believe many of you will have the opportunity tomorrow morning to visit the Emergency Operations Center to see how we manage large national responses. We have a number of activities in Indian Country, and until recently, we had the pleasure of hosting Craig Wilkins in our shop. Those activities revolve around local planning with our state and local partners and then there's also some activities with academic centers across the United States to help with educational-related efforts, and I'll be glad later to add something to the record of what those specific collaborations consist of. Thank you very much.

Councilman Antone: Thank you, and we'll go to CAPT Jonathan Mermin, National Center for HIV/AIDS.

CAPT Jonathan Mermin: Good morning Councilmen. I am very pleased to be here, and I look forward to the session. My center is involved with HIV, sexually-transmitted diseases, viral hepatitis, and tuberculosis prevention, the leading causes of health disparities in the nation, and most of these diseases are both more common in Indian Country and also often stigmatize everywhere in the nation, and what that means is that it highlights some of the complexities of working with public health in that environment. All of the infections are preventable and all are treatable, but most are chronic infectious diseases and perhaps by happenstance, our budget is similar to Dr. Bauer's, but our chronic infections are either treatable like HIV or hepatitis B or potentially curable if you

find them like tuberculosis, hepatitis C, human papilloma virus, and syphilis. But because they can live dormant in people for many years, they're often silently causing problems over time. We support programs, policies, and provide information throughout our programs to be able to have the greatest effect on reducing morbidity and mortality and reducing disparities, and we provide accurate information in times that are often changing, so as new information is available on potential ways to prevent HIV infection, we try to get that information out as well as new treatments for things like hepatitis C infection. We also are responsible for surveillance for these infections and last year produced an HIV surveillance report in Indian Country which was a great success and continue to focus on providing accurate information to the nation so that they can respond to the epidemics. We have extensive collaborations with a variety of HHS agencies including IHS which has a small office related to our infections but in fact often comes to us for either collaboration or information, and later today, you'll have two presentations from experts in our center. One is Dr. Donna McCree and the other is Jo Valentine who'll be presenting in the behavioral risk reduction session, so you'll have a chance to both talk with them later and also I'd be happy to discuss things today.

Councilman Antone: Thank you. Go ahead. Dr. Mermin, is that correct?

CAPT Mermin: That's correct, thanks.

Chairman Steve Cadue: Steve Cadue, Kickapoo Nation. In the news media reports, there's been a spike in some of these infectious diseases in Indian Country?

CAPT Mermin: Correct.

Chairman Steve Cadue: And what's been the CDC's response to that?

CAPT Mermin: In certain areas, we've actually worked with either local authorities or actually had people come out to try to help figure out what's going on. Some of the infections cluster in certain areas. For example, HIV which is sexually transmitted can spread in a local environment because of sexual networks, and we've been able to diagnose people quickly and provide them treatment which then prevents further spread. We've also been working with IHS and different nations to try to expand some of the interventions that are known to be effective, whether that's screening people for tuberculosis and HIV or hepatitis C which is a chronic infection that affects over three million people in the US including in Indian Country and is both under-diagnosed and leads to liver failure over many years of infection and yet, there's now much better treatment that's available that can cure people, so one of our efforts over the next few years is to expand access to both testing and treatment for hepatitis.

Councilman Antone: Dr. Judith Monroe, Director of OSTLTS.

Dr. Monroe: Thank you. So I had the privilege of giving you an update earlier this morning on OSTLTS. The one thing that I would like to add that I didn't include this morning, and it comes from a great conversation I had with Tim Gilbert last night at dinner regarding physicians working in Indian Country or other healthcare workers that we have a need to understand population health and public health. That's actually something that we have been working on out of our office through graduate medical education along with others across CDC, so I would be very interested in working more deliberately and focused on how we might help all of you with your healthcare workers understand population health as we go forward.

Councilman Antone: Thank you, Judith, and then we'll have Tanja Popovic, ATSDR, environmental health.

Dr. Tanja Popovic: Good morning and thank you for the opportunity to speak. I represent the National Center for Environmental Health and Agency for Toxic Substances and Disease Registry and I have the longest title of everybody here. It is the agency and organizational unit of CDC that is focused on preventing our environment, and I think this is maybe one that can be closest to the technique of the seven generation because we want to protect our environment for all the generations that are coming after us and be enjoying the same things that we're enjoying here. We have, as I said, two organizational units that have little bit different roles. One is primarily to prevent and respond to environmental emergencies and hazards, so this is the Agency of Toxic Substances and Disease Registry. The other one, National Center for Environmental Health, has several key areas that you may be familiar with such as focusing on prevention and control of asthma, prevention of childhood lead poisoning and lead poisoning in general. Focus on climate change and everything that we can do as public health officials to ensure people can deal with effects of climate change. There is also a major organizational unit which is our Division of Laboratory Sciences that does a lot of collaborative work across CDC with different organizational parts. So, for example, all the work that is conducted in terms of testing for tobacco is done within one of those laboratories. Newborn screening testing is done in one of the laboratories within that unit. Our NCEH/ATSDR is also specific because we also have our own Office of Tribal Affairs and Dr. Anabelle Allison is here, and I'm sure you all know her very well, and she will be continuing to be engaged with you throughout the day. Finally, one of the activities that is very specific to our center is the Birth Cohort Study of the Navajo Women regarding potential exposure to uranium, and as you likely know, just to emphasize, we have received all the approvals and are now in the stage of recruiting. Thank you.

Councilman Antone: Thank you. Next, we go to Anne Schuchat, National Center for Immunization and Respiratory Diseases.

Dr. Anne Schuchat: Good morning. I run the Immunization and Respiratory Center for CDC, and we coordinate all of the vaccine-related activities that CDC does. Those range from the laboratory that tests the influenza strands that are circulating and helps select what will go into the annual flu vaccine all the way to administering and leading the vaccines for Children Program Entitlement. The Vaccines for Children Program Entitlement for the past 20 years has provided free vaccines for children up through the age of 18 who are either uninsured, Medicaid eligible, or all children who are American Indian or Alaskan Native. The entitlement program doesn't directly deliver the vaccines. Children are eligible for free vaccines through the program, but CDC buys the vaccines and ships them out to over 45,000 clinic sites. We estimate that about 165 million dollars' worth of vaccines are bought for the American Indian or Alaskan Native children in the US. That entitlement program has helped eliminate or majorly reduce disparities in childhood immunization and has helped us sustain the elimination of measles and the dramatic reduction of vaccine-preventable diseases including pneumonia caused by the pneumococcal infection and Haemophilus influenza B meningitis, both problems that disproportionately affected Indian children. The priorities for our program include always being ready to detect and control the next respiratory threat, whether it be a new pandemic of influenza or a new emerging virus like the Middle East Respiratory Syndrome virus. Our immunization priorities include sustaining the infrastructure that supports the nation's immunization system, whether it's surveillance and the evidence based or the public health staff that support the clinicians that are actually delivering vaccines and to modernize the immunization system primarily through information technology with immunization registries and electronic health records and strengthening the links between them. Another priority is to address lagging immunization indicators. I'm not sure if Dr. Frieden mentioned it, but a key priority for us right now is to improve protection against HPV-related cancers, the primary cause of cervical cancer and several other cancers that we can now prevent through immunization of teens at 11 or 12. We're as a nation doing very poorly in increasing uptake of the HPV vaccine, so our center is working actively on that to try to address that since it is so precious to be able to prevent a cancer with a vaccine. Working to learn how we can work in closer partnership. We're very proud of the Vaccines for Children program and the successes it's had, and this afternoon, Melinda Wharton who runs the Immunization Services Division will be meeting with you in a little bit more detail about that program and ways we can strengthen the partnership.

Councilman Antone: Thank you, Ann, and lastly, we have Grant Baldwin, Division of Unintentional Injury Prevention.

Dr. Grant Baldwin: Good morning everybody. I am certainly honored and privileged to be here as well, and let me add my welcome. I'm here representing Dr. Dan Sosin who directs the National Center for Injury Prevention and Control. I direct one of the three

divisions at the Injury Center, the one focused on unintentional injury prevention. Much like our colleagues at Birth Defects, we're a relatively small center. Our budget is around 145 million dollars, but we consider ourselves small and mighty. We have four focal areas. You heard from my colleagues yesterday, Dr. Ann Dellinger and Captain Holly Billie about one of our treasured programs, the motor vehicle injury prevention work. And I'll speak a little bit more about that in a second, but our other three priorities are prescription drug overdose prevention, traumatic brain injury prevention, and the prevention of violence against children and youth. The motor vehicle injury prevention program is a treasure of ours for three specific reasons. First because of who we serve, second because of the success we've had, and third because of the really impressive cost effectiveness of that work. We've been challenged by Drs. Frieden and Sosin to reevaluate where we want to take that program in years to come. We've had great success which you heard about yesterday in the eight tribes that we work closely with. We were challenged with issues of scalability to think about how we can serve more of Indian Country, and so we've produced both lessons learned and best practices documents and we're migrating to a technical assistance approach, working with federal highway officials. I certainly have a lot of sensitivity to the issue that was raised in the session with Dr. Frieden about suicide prevention, but I'll mention another issue that is high on our list of priorities working in Indian Country, and that's older adult fall prevention, so working with colleagues in the Indian Health Service. We're looking to adapt and make culturally appropriate and relevant some community-based fall prevention programs and colleagues of ours in Canada are also working with the Indian Health Service and us to think about how we can do more with older adult fall prevention. And lastly, I'll mention – Dr. Frieden talked a little bit about prescription drug overdose prevention. We're also looking to expand work in Indian Country on that issue as well, so thank you.

Councilman Antone: Thank you and just want to make a comment before I turn it over to whomever might want to ask some questions. I'm very enlightened to see all of you here because my hope is that – and it may be CDC doing it, is to be able to use all the centers to address issues that might require many centers. I know that CDC a few years back attempted to address suicide with SAMHSA, IHS, and NIH and we had that meeting up in Rockville, so to me it's possible that we can take this to that higher level of other agencies, you know, that concept of crossing over into other centers to address a health issue. If we can do that and be able to convey that message to other agencies, then I think we're better off, all of us because then we have these different jurisdictions working together whereas in the past, we didn't do that. I know that CDC's consultation back in 2008, I believe in Tucson, we suggested EPA being involved in the water issue along with CDC and Indian Health Service. CDC said this is our jurisdiction, our consultation, but now I think we're at that point where we can do that and here, there are certain jurisdictions, but we can cross over now, I've seen it happen, at least in a meeting, but if we can continue to do that, I think we're probably further ahead in

addressing issues than we were previously. I just want to make that comment because we do run into that out there, and I'm glad CDC has everyone here so we can discuss what we need to talk about and that at least you're made aware that we're aware of where those centers are that could possibly help us in that regard. So I'm going to stop there and I'm going to ask anybody if they – Mr. Hicks?

Chief Michell Hicks: Good morning. Thank you for the opportunity to be here and to be part of this process. I have a question first of all for Dr. Bauer. I guess if you looked at the Tribal Epidemiology Centers, public health authorities, of course working on behalf of tribes, they need access to data sets that lend themselves to linking with other tribal information. So my question is based on your comments is what can the CDC do to assist with this barrier to identifying key health issues within our tribes and I guess, you know, it also relates back to just classification based on Census data. What are you guys doing to improve that particular area?

Dr. Bauer: Thank you for the question. It's a really important issue and as Dr. Frieden noted in his remarks, we'll certainly work with our office of surveillance and public health science to make available the data that we have control over to ensure that the epi centers are able to use those data productively. I can't speak to how we work with census bureau, if we do work with census bureau in terms of classification, but we do have an exciting initiative that's coming to fruition this year which speaks to better classification of race and ethnicity in the death data, so you'll see a nice supplement to the American Journal of Public Health that's based on merged data sets between the National Death Index and the Indian Health Service Data, and we've seen enormous misclassification. By merging those data systems, we're able to capture many more American Indian and Alaska Native deaths, and we see that in some cases, the disparities in fact are even greater than we had understood previously. So that's an effort that we've been working with collaborators across Indian Country and across academia to do these analyses and get that information out. We are also exploring opportunities, and as I mentioned, I will follow up on Dr. Frieden's commitment from this morning to see how we can better support the tribal epi centers, whether that means grants that we can provide or technical assistance that we might provide or even looking at some of our programs like PHAP to provide the human capital resources, so we look forward to exploring some of those opportunities.

Chief Hicks: Thank you for your response. My next question is to Dr. Daniel related to, I guess, communication. In Cherokee, we're blessed with an opportunity to do a comprehensive healthcare and have a very comprehensive healthcare system. We're getting ready to build a new hospital. We're using some knowledge from the Alaskan tribes to assist us with efficiencies and things of that nature. One of the things that we've been very involved in the last 10-15 years is preventive healthcare. Obviously, within IHS facility historically, the focus was not about preventive care, it was simply

when you got sick, you were hopefully taken care of. So we've tried to change that over time, and by doing that, we've issued – within the employee base, we have currently almost five thousand employees total. A mandatory health check for those employees. Of course, we are self-insured so our hope is sometime in the future, we're going to save money for the tribe, and so again, we've been giving ourselves an opportunity hopefully to do that. One of the key areas that I've seen a lot of change in is a few years back, 3-4 years ago, First Lady Obama initiated a Let's Move program, focused on youth. We were able to create some commercials that basically were able to broadcast in the area of where we live, but also one of the things that I felt that came out of these commercials and obviously, they were health related, was we're starting to see things improve such as we're seeing walking clubs now, we're seeing running clubs. We created a gardening program for both elders and youth, and I guess the other things that we've done is we began to issue certain admin leave, if you will, for tribal employees that are active during lunch or want to create a time to play basketball, work out, whatever is their interest. But my question to you guys is what more can we do because I think, again, of all the things that we're working on preventive health-wise, the commercials seemed to have had the biggest impact, and so what can we do to improve that message, both regionally for individual tribes and, of course, nationally because I think there's a great message that could be created, especially with tribal leaders stepping up, and unfortunately, I've dealt with high blood pressure for about four years now. It's genetically – you know, it had been handed to me and it's tough at times, but as a tribal leader, I feel my responsibility is to step up and be an example, but I think there's opportunities through communication to do a lot better job than what we're doing. And even on the national level. I'm sure, again, a lot of tribal leaders would step up and be willing to participate to send the proper message to our tribal members and to all US citizens. Long question, but it's important to Eastern Band. [

Dr. Katherine Lyon Daniel: There's a lot of really important things in there. One of the both challenging and exciting things about being in the field of communication is that nobody ever says to you it's done. Because there's always more that you can say and there's always more that people want to know. So it sounds to me like you've headed down a great road for the challenge that you are facing and for the things you want to accomplish. My guidance at this point would be in working alongside us with whatever way that we could would be to capture the stories of the people in your communities and tell those stories because you have the celebrity stories, which is the Michelle Obama and whatever other celebrity is in the news. Those can cut both ways because a lot of times, just as much as someone loves their national celebrity, there are just as many people who don't want to hear about them. But your local celebrities and your local leaders can tell fascinating stories about the struggles that they go through, what worked for them. You've heard probably about the TIPS campaign for former smokers. Those are real people who told the stories about how smoking or being around smoke affected their lives and didn't allow them to lead the lives they want to live, and if that

helps get at this psychological barrier that we all have in trying to prevent something that hasn't become real to us yet, it's to prove a negative. You don't know if what you're doing is preventing anything you would have had in the first place, so it's the hardest challenge that you face. But telling people a story about a person or a family or someone that they can really relate to can make that outcome real for them and real enough that they want to act. So that would be one of the first things I would do is continue down the road of selecting real people, whether it's you or other leaders who talk about your struggles and what works for you and finding people who for whatever way they sort of personify the ideal to the community. You hear about someone whose experienced a tragic loss and that person can come up and tell the story about prevention in a way that none of the rest of us can. Using those stories and then talking with the people in your community that you're trying to reach about which ones work for them. So when we are doing broad-based communication campaigns toward an outcome, it often happens that the very last thing we do is spend time and money on evaluating the messages with the audience, but it's so critical. And it's one of the things that just because we create something, we think it's wonderful. If the target audience doesn't get it or is confused by it or thinks it's something else, you've pretty much wasted all your time and energy and, of course, you don't want to do that. So I would suggest the story building, the audience research, and the building that strategy down the road of how you're going to approach all the different goals you have to bring the leading causes in under the other things that people go for and sort of connect those two together will give you a greater chance of success. And while I'm offering the resource, I want to go back to this communication resource center, so in our group, I know many of you have your own communication resources which are closer to your communities, so probably relevant in many ways we may not be, but we can provide images. We can provide videos. We can provide templates. We can even help with audience research. We have a lot of ways to help you get those pieces in place so that when you get ready to do a campaign to help, you're doing it with just that much more to assist you.

Chief Hicks: Thank you for your response, and if you would, if I could share contact information please. Thank you.

Dr. Lyon Daniel: Certainly, sure.

Dr. Ursula Bauer: If I can add to that. Thank you. I would just draw your attention to the Native Diabetes Wellness Program where one of the activities that Eastern Band of Cherokee have been engaged in is cultivating those stories and telling those stories and I would urge you, in addition to using those stories to motivate behavior change among your people, take those stories to your congressional delegation because they're the ones who need to hear this program is working in my community and I need to grow and expand the program or there's a huge unmet need in my community and I need

resources to address it. So never forget the advocacy potential of these stories as well. Thank you.

Councilman Antone: If I may, I'll take this opportunity since nobody's raised their hand. I'm going to go ahead and I'll recognize after I finish, Cathy. I was looking into my notes as I was writing real fast, but I wanted to address a question to the CMS person who works – okay. As I recall your conversation, you analyze data for CMS or did I misunderstand you?

Corrine Graffunder: Yeah, I might have misrepresented that in some way. We're working closely with CMS to look at how we can collaborate in effectively integrating population health data so the kinds of data that CDC has into some of the innovation work that they're doing around experiments that are going on in the field and even starting to have some conversations around some of their more standard systems of care, so it's in the early stages and it's very much about how do we – Dr. Frieden talks about triangulating data, how do we think about how as they have clinical care data, they have clinical data coming from their clinical encounters, how can we use population health data to help them contextualize that data, so it's a path that we're on and we're pursuing a number of opportunities, and we're really working across the agency – we don't own any of the data in the policy office. We don't have any of the data that sits with us, so we're really working in all the centers and programs where the data sit or in other parts of our agency in helping broker that conversation.

Councilman Antone: I'm again encouraged by that because I think when you're seeing systems of care, your center has a large role to play in the implementation of the Affordable Care Act with CMS and I just want to let you know within the State of Arizona and CMS is essential health benefits, but essential health benefits don't address podiatry. They don't address emergency dental. They don't address orthotics nor do they address occupational therapy and yet, I think as you analyze along with CMS how those – what they call optional benefits are going to in the end probably raise healthcare costs at least to specific populations as you say because they all go together. The State of Arizona has said in the 1115 Waiver – CMS does not require us to provide those optional benefits and yet, the overall goal of the Affordable Care Act is to decrease healthcare costs, so somehow, that doesn't – unless I'm not understanding it – defies any kind of logic that I know of. So in that sense, your work is going to help support tribes, particularly in Arizona, to advocate to include that. We have had that included but that's not a part of that Waiver. At that time, it was uncompensated care cost. The tribes were able to get reimbursement from that. With that reimbursement, Indian Health Service is able to provide other services, better services. So when we're talking a system of care, we're looking at being able to build on that Indian Health Service, and it relates directly to Ms. Bauer's chronic disease center. And that's what I want to let you know because – if you analyze it further, you'll see what I'm talking

about, and you probably already do. I saw you smiling about the logic part of it, but I want to leave you with that because our tribes are going to need to support to ask State of Arizona to include that in the Waiver and I think the ITCA is going to – the Intertribal Council of Arizona – we’re going to again discuss the possibility of continuing the uncompensated care costs because of the prevalence rate of diabetes in Indian Country. And I want to leave you with that for that one and then the other issue that I want to bring is the fetal alcohol spectrum disorder. That was within the IHS budget years ago. It’s not in the budget, and again, the logic is something that I can’t understand. Because if you have developmental disability from birth, you’re going to probably have a greater learning disability, so by the time you’re an adult, what do you have? You probably have certificates of completion of grade school, certificates of completion of high school, but how do you get a job? The different ways of learning that these individuals have to go through, they can learn. My niece has a job as a correctional officer, and she’s FAS. To me, that speaks loudly because she raises a family, works. They can do it, but why that’s not a priority, I can’t understand it. The other thing is the RMSF. Tohono O’odham Nation is very lucky that we haven’t had a death because we’re constantly trying to do what we can to not get there. We need some assistance. When I talk about multi-jurisdictional efforts or talk about perhaps the US Army, as has been suggested in the past, maybe they can neuter and spay as a training. The pens that the military use to house Al-Qaida members, they put that up real fast. I think they can do the same in Indian Country, but we need that go between to help us talk to them. We need the experts to say you can do this because one of the main reasons for RMSF is the free roaming dogs because particularly smaller tribes don’t have that structure to be able to oversee, to be able to build, so I want to leave that with the RMSF folks. The bedbugs issue that I mentioned, diabetes, scratching. You get a sore and if you’re diabetic, it’s slow to heal. If it’s on your leg, you better watch out. And then the other one is the environment. I’m very encouraged by the presentation by Anabelle Allison yesterday, but I also think that, as Mr. Jim stated, we need to consult on that product just to let you know, and I think I’m going to end there and maybe some feedback and then after the feedback, I’m going to recognize Cathy and then after Cathy will be Herman. Thank you. Go ahead. If there’s going to be no response, I’ll move to Cathy.

Cathy Abramson: Alright. There have been studies that show American Indian, Alaskan Native children are sometimes over vaccinated. Are there ways CDC can work with IHS to address this issue and improve incidence of over vaccination?

Dr. Anne Schuchat: Thank you. The best approach to assure that the right vaccines are given at the right time is through immunization information systems and electronic medical records, and I know that we have been working closely with IHS on strengthening what we call interoperability, the message transmissions between those. To some extent, IHS has been a model of focusing on this in some of the pediatric

communities, and there's more to do but the way to make sure that children get the vaccines they need is to know what they've already had and to build clinical decision support into the system that the provider's looking at. So you immediately get a record of what's due, what have they already had, what's overdue. You can also use those systems to remind parents about that it's time to come back for another shot or recall them when it's overdue. You know, with our partnership with IHS, we've been working on that and I think we've made a lot of progress. I don't know that there is more over vaccination in one population than another. We've really focused on the under vaccination issue, people who are missing doses or are late on doses as a priority, but we think the electronic systems are going to be the key. At this point, there are 16 different diseases that are vaccine preventable, and there are dozens and dozens of injections or doses that kids get by the age of six alone, so we think it really takes the computer to help us know what's due or overdue.

Director Cathy Abramson: Thank you. Then also there are not many American Indian-specific evidence-based practices to address public health issues. Can CDC look at ways to improve the evidence base for Indian Country and can you look at creating funding streams to have this as a goal?

Dr. Ursula Bauer: Sure, I'll jump in there. Thank you for the question. So I guess a quick response is that that actually was one of the goals of the community transformation grants. Written in statute was to improve the evidence base for community prevention and with the elimination of those grants, we've now lost an opportunity to do that across the country as well as in Indian Country. We have been asked by the TAC in years past specific to chronic disease to compile best practices from Indian Country and we are working closely with OSTLTS to do that and so I can provide you with an update at a later time. I didn't check in with that project before I came this morning, but that is something that's under development that we do hope to share with you in the near future. We also – Dr. Frieden mentioned the Guide to Community Preventive Services and many of those strategies do work well in Indian Country. Often, they need to be customized to be relevant to a specific community, whether that's in Indian Country or elsewhere, but those broad strategies often do work well and the lessons we want to capture is how do we take those broad strategies and customize them for different populations. I have done some listening of my own with tribal leaders across the country to try to better understand how my center can serve Indian Country, and one of the requests I hear over and over again is creating opportunities for tribes to share their best practices with each other. And I know that happens informally and formally in a number of ways, but as we develop future grant programs for Indian Country, we will look at how we can be sure to build in that kind of sharing of best practices among tribes so that you can benefit from the expertise and the wisdom within Indian Country.

Director Abramson: Thank you.

Councilman Antone: Before I go to you, Herman, I'm going to ask Chesley Richards to give about a three-minute presentation to us and then I'll go to you, Herman.

Dr. Chesley Richards: Thank you very much. I'm sorry for being late. I had another appointment that I had to attend to. I'm pleased to be here today to represent the Center for Surveillance Epidemiology and Laboratory Services. I am the Director of the Office of Public Health Scientific Services which includes the National Center for Health Statistics and the Center for Surveillance Epidemiology and Laboratory Services. The Center for Surveillance Epidemiology and Laboratory Services has broad responsibilities at the agency for surveillance. We run the National Notifiable Disease Surveillance System and also the BioSense program that's for situational awareness around the country for public health events. We also have the epidemiology programs including Epi Info. We have the EIS program. We have the Task Force for Community Preventive Services and we have – we run the CLIA program for clinical laboratory improvements. We co-run that program with CMS, so we have a broad range of crosscutting activities that affect many of the areas of public health. I think we're interested in listening and hearing what interests you have or concerns you have or what ideas you have in the ways that our center can support your efforts, so I'll give back most of my time and hopefully can listen and have questions.

Councilman Antone: I'm going to recognize Herman Honanie, Chairman of the Hopi Tribe and then after that, it'll be Jay Butler and then Tim Gilbert.

Chairman Honanie: Thank you, Chairman. Herman Honanie, Chairman Hopi Tribe. First of all, I just want to say to all the Directors and programs within CDC, thank you for being here and thank you for sharing your program activities and the updates and all the information that you've provided us. It's very, very interesting and I say that because when I look at the health of especially my people and all the issues that we're facing at home in some ways, specific or broad or in between, you all have something to offer and we all have something to ask in terms of resource and so forth, but at the same time, as the gentleman to my right, Chairman Hicks stated that individuals in leadership position really need to take it to the point where we have to take the lead in directing – maybe not so much directing but speaking to the health of our people, but I view all of you as resources. And there's a reason why each one of these agencies federally have been created and I'm sitting here listening to you, and that's part of the reason why that you all have a future responsibility, not only so much to Indian Country but to the nation and to the world and so that's an awesome – that's a broad, broad responsibility and I really commend you for all that because it's a really huge – it's a big responsibility. It's a big job and I think that Indian Country really needs to look at you and see what it is that you have. I'm here for the first time to listen and hear all of this, and so I'm really

thinking and I'm trying to absorb as much as I can and I don't know if this is everybody within CDC but there are also other programs out there. Someone mentioned the lack of SAMHSA being here and then other programs, but somehow, their program – those issues are related to what you all do, so I don't know Mr. Chairman, maybe you can use your influence and get the full federal government to some central reservation and we can hold a bit pow-wow out there. I don't know, but it's something that we really need to look at and be able to understand every facet of every program. Maybe that's an impossible task but I just want to commend you and thank you for that. But I also wanted to ask and I just now realized that there's no funding in the area of fetal alcohol syndrome I think as I know it, and it really concerns me because ever since my wife informed me about it – she works in the schools and she sees that problem so much and she comes home and talks about it and I've come to realize that it is a bigger issue than I realized than I've ever taken it to be. And I don't know what the picture is across Indian Country today. I'm just wondering what we can do if there's no funding available. At the same time, I imagine that at the local level, we should be able to continue addressing it. We should be able to continue talking about it. And I get really, really kind of I guess frustrated when I hear of so much of this type of disease, I'll call it, present when she comes home and tells me about that, and, you know, I just kind of get to the point where I'm helpless. I mean somebody's got to do something. Somebody's got to say something to these – especially to these young women who are pregnant and are of child-bearing age. Yesterday, I mentioned our social media, Facebook, and just before we were headed to the Super Bowl game, a lot of people – women included – young ladies included of my people; sadly, I was seeing beer commercials being advertised and being oh, this is what I like, this is my favorite drink. And it just really saddened me and so the day before or a couple of days before the Super Bowl, I announced in Council and I said to them – Council, will you support me if I get on Facebook and blast everybody and say no more beer commercial posting and I looked around in hopes of a response. Not a single response. Not a single response. In my own heart and in my own inside me, I said it's [speaking in Hopi][inaudible 156:49]. It's [speaking in Hopi][inaudible]. I said oh no, oh my, doesn't anybody not have any regard in even thinking about this and what a problem it is. And so again, I guess I just go to the point and make reference that we as leaders have to talk to the issue and really have to cross that line and really make that register voice and say we need to go the other direction. We need to stop this. We need to counter that because our kids are suffering. And as Chairman Antone, you know, we have a sizeable number of special needs population on our reservation, too, and it's a challenge and once they get to adult age, training and securing of jobs and other things like that is really, really difficult and the Director of the Office of Special Needs was just in my office Friday afternoon saying Mr. Chairman, what am I going to do. Maybe we possibly – our funding is in jeopardy, we have X number of clients, and some are adult and some are trying to support themselves and so on and so forth. What are we going to do with that, you know, and so it's really an issue that I'm really concerned about and somehow we need to fight that

head on. So anything you can do to be able to help us out there, that's really going to be helpful out there. The other matter is of suicide prevention. You know, we Hopis also have a saying that [speaking in Hopi][inaudible 158:25]. It means literally that when you get tired of life, you take yourself, you take your life, and you don't want to continue with life for whatever reason. And in Hopi, that has a greater and broader and deeper meaning but that's something that we've always wrestled with and we have a high suicide rate, too. That also needs to be addressed accordingly, and I'm sure we're not the only one that has that challenge. With regard to HIV, I've always been interested in and wondering if the numbers in Indian Country have increased or is it constant or is it going down, and I'm hoping it's gone down but I really have not been caught up with the latest data or numbers on that. But it's everywhere, and we have been referring to it in Hopi as a disease [speaking in Hopi][inaudible 159:19], meaning - because as far as I know, and my people first started talking about what is AIDS. What is the disease and what does it come from, how does it develop? Well, we eventually got educated on that but what really is it and so forth, so that's something that we've really grown a lot to educate our people on but still, we have it amongst ourselves as a people and so it's really alarming and really, really concerning to us overall. And these are just kind of the issues and concerns that I have, and I hope that we can be able to speak to them in more specificity so that we can be able to show, again, our people the numbers and what it's doing. And we have potential and capacity to be able to prevent many of these diseases that we're facing around here, so I just want to say thank you all for your time and efforts in your jobs respectively. Thank you very much.

Chairman Antone: Thank you, Chairman. I'm going to go to Mr. Jay Butler at this time.

Dr. Jay Butler: Thank you, Mr. Chairman. I have the honor of having been appointed by the Alaska Tribal Caucus to serve as the Alaska Area authorized representative. I wanted to touch on a few of the issues that were raised this morning. In Alaska, we have a vision that Native people will be the healthiest people in the world, and it's a big audacious vision. To achieve that vision, we believe that it's important to reclaim the health and resiliency that are inherent in who Native people are and also to address some of the specific challenges that we've had highlighted this morning in Dr. Frieden's presentation, addressing disparities and inequities in health. When I meet skeptics, I often like to talk about viral hepatitis as one of the areas where we can address problems and make a difference. We have virtually eliminated all new cases of chronic hepatitis B, previously a major health challenge, a major driver in hepatic cancer among Alaskan Native people. We have – knock wood – eliminated the usual epidemics of hepatitis A as well. And I'm already looking at Dr. Mermin because I do have a request. One of our challenges now and promises is to really be able to address hepatitis C. Although our rates are no higher than in other parts of the country, it's a challenge for all Americans. And it's a challenge for us in Indian Country because it is such an expensive resource to address. We now have medications that can achieve up to 90%

cure rates, even addressing some of the most challenging genotypes of the virus, yet even at the federal contract price, we're looking at a minimum for just that one component of a two to three drug regimen about 65 thousand dollars a course. That is a show stopper. I'm aware that CDC has quite a bit of experience in addressing some of the ethics surrounding the equitable distribution of scarce resources, and this is a scarce resource for us because it's a fairly small portion of our customer owners who have third-party payers who are willing to cover the cost of these medications. So assistance in being able to identify the patients who are most likely to benefit from treatment and really would be most appropriate to be prioritized would be very helpful to us in addition to pushing on your sister agency, CMS, and throughout the federal third-party payer system to recognize the importance of this. I realize the experience is probably different in the various states, but currently, for us in Alaska, for instance, Sofosbuvir is only covered if you've previously failed treatment and the PND committee for making those decisions doesn't even meet until in November at which time we'll probably have even more drugs. Unfortunately, probably no cheaper but those are very challenging issues for us and we would look forward to continuing to work with CDC on those issues. Dr. Bauer, we appreciate the work that we've had with you in traditional foods. We strongly feel that traditional foods is an important and vital part of reclaiming that health that is inherent to Native people. We are very interested in looking further about how to establish the tastes for the traditional foods or first foods as they say in the Northwest, early in life. And we have a lot of interest in being able to develop guides for young mothers once they're weaning their children to understand that the food in the jar is not always the best thing. But we also want to be able to establish that this is indeed a helpful practice. Also, in your shop I believe is oral health. A great example of a disease of colonization if you will and an area where we believe traditional foods could make a difference. It was only 80 years ago when some of the first missionary dentists came in to Western Alaska and wrote of seeing some of the healthiest teeth they'd ever seen in the world, so it's very clear that there has been a change. Regardless of the infectious disease model of dental caries, we know that the diet has had a major change there. But at the same time, just changing the diet won't get us to where we need to be. There are too many very young children that are having full-mouth restorations. Too often, the norm is having complete extractions by early to middle adulthood, and so being able to establish the role of the mid-level provider, not helicopter dentist dropping in but are there health benefits from for instance the dental health aid therapists, and while that's a program that's been active in Alaska, there are many state legislatures around the country that are addressing that question right now. I know Washington State has some legislation that's actually been introduced to be able to address this. The assistance of CDC to be able to document the benefits of this kind of provider or lack thereof would certainly help in that debate. Dr. Schuchat, if I could return to Director Abramson's questions about documentation of vaccination. I think there's a very unique role for CDC in leadership in working with the vendors of electronic health records. EHRs are not going to go away and I have to say, as a director of infection

control, I don't know how I lived before we had them. But at the same time, as we transition to these commercially available products which oftentimes don't have the population-based approach to health management or a public health approach, really focus more on things like billing if you will and good documentation, and there's nothing wrong with that. We've actually lost some of the gains that we've had in the past, and that's particularly true with immunizations. CDC had a great working partnership with Indian Health Service in establishing vaccine tracking, forecasting, visibility through the RPMS system but most of us in tribally administered organizations have moved away from RPMS because of the importance of other issues such as the revenue stream and certainly, I can say for us in Alaska, that's been a step back in terms of being able to do the kind of documentation that's necessary to address the questions of over immunization or under immunization. Thank you.

Councilman Antone: Thank you, Mr. Butler. And now the next person that I have will be Mr. Tim Gilbert and then after Tim will be Mr. Sampson.

Councilman Leslie Sampson: Thank you, Mr. Chair. Can we get information on [inaudible] levels of vitamin D and the benefits of taking vitamin D?

Councilman Antone: Mr. Sampson, can you repeat your question?

Councilman Sampson: Okay, can I get information on impact of low levels of vitamin D and the benefits of taking vitamin D?

Dr. Ursula Bauer: I can maybe address that a little bit. We have or are looking at vitamin D and its relationship to preterm birth in African American women. We don't have an answer yet in terms of that relationship. Vitamin D is fortified in milk so that we should be – if we're drinking milk, we should be getting the amount of vitamin D that we need. Vitamin D is a fat-soluble vitamin, so it does stay in the body longer than a water-soluble vitamin. So one needs to be careful about overdosing on vitamin D. There's certainly a lot of attention to vitamin D now. Theories about its relationship to depression, its relationship to overall health, and these are claims that we haven't evaluated and don't have a lot of evidence for.

Dr. Grant Baldwin: From the injury perspective, I can provide information about the relationship between vitamin D and older adult fall prevention as well. I'll be happy to provide follow up on that.

Dr. Jonathan Mermin: If I could add, Mr. Sampson, we've just completed a study looking at vitamin D levels in Alaskan Native children in a collaboration with Alaskan Native Medical Center and have seen increasing rates of vitamin D deficiency the farther north

you go in Alaska and connecting that with vitamin D deficiency in rickets, so I can provide you more information about the specifics of that and plans for follow up.

Dr. Ursula Bauer: If I could respond to Dr. Butler's previous comments before we move on? Is that –

Councilman Antone: Well, let me go ahead and continue with Mr. Sampson. There's an additional question you wanted to ask?

Councilman Sampson: I didn't get that.

Councilman Antone: Were you going to ask some additional questions?

Councilman Sampson: No.

Councilman Antone: Okay, go ahead Ms. Bauer.

Dr. Bauer: I just want – on the issue of food preference of young children, I certainly appreciate your support of the traditional foods program and that's one that we struggle to sustain and expand and continue to look for ways to do that. There is some emerging evidence about the food preference of children really being developed in utero and during the time of breastfeeding, so mom's diet during pregnancy is very important to set those food preferences in place and, of course, breastfeeding is critically important for a number of issues including oral health issues in young children. But now, it appears that may be related to establishing those food preferences as well. We have a small program to promote breastfeeding within the Chronic Disease Center and we did receive a small additional appropriation for that program this year and so we can look at how we might deploy those dollars across the country and in Indian Country to promote breastfeeding.

Councilman Antone: Thank you. I'm going to recognize Tim Gilbert and thank you for –

Mr. Tim Gilbert: Thank you, Mr. Chair. I guess I wanted to add my gratitude for each of your sharing here this morning. I feel like I can sit down with each one of you individually and learn a lot about how to benefit our programs. I do have two specific questions. The first one is trying to connect the dots between some information that Dr. Frieden shared with what you shared, Dr. Bauer, yesterday with regard to the up and coming new primary prevention monies. This may be a two-part question. I'm not sure how to phrase this. Is there extra added value in the review of a proposal if somebody was to submit a proposal when the RFP comes out for the primary prevention opportunity of incorporating some of the concepts that your directors shared this morning and I'm thinking specifically of the Million Hearts program, the ABCs, so first

part of that question is there added value in picking up some of those strategies and applying them to perhaps a Native community like ours and the second part of that question is maybe you could share with us the review process at this level that helps ensure that there's alignment between what you're funding with what your directors saying is important. So that's my first question, I guess it's twofold. And the second one is back to Dr. Baldwin and your mention of the work with prescription drug use and mortality. We were talking about this over dinner last night. A huge problem for us – I would misstate the mortality data if I tried to do it by heart for Oregon but it's alarming and I have a sense that it's a problem in other areas of Indian Country, but we would be most interested in –

Councilman Chester Antone: Thank you, Tim. Anybody want to respond?

Dr. Ursula Bauer: Yes, please. Thank you very much for that question. In terms of our funding opportunity announcements, the biggest key to success is to respond very carefully to what's asked in the funding opportunity announcement. So it's generally not a good idea to add additional information because people who are not familiar with the program are actually the ones who are scoring those applications so that's the objective part of that review so it's not the people who are going to work on the program who read those applications but people who are objective who don't have that content knowledge. So they're looking at what the funding opportunity announcement requested that you stayed within the parameters and then measuring how well you met that requirement of the funding opportunity. So I would discourage anyone from trying to add things in and do more than is asked for in the funding opportunity announcement. And to drive that point home, there's always a statement that says if you ask for more money than we are offering, you will be automatically eliminated from the review process, so the FOA is really very prescriptive. When we design new grant programs, we certainly try to take into account and follow the strategic priorities of the agency but as Dr. Frieden mentioned, our budget is determined by congress. Congress provides us with dollars in discrete lines. He said the agency had about 200 different budget line items. In the chronic disease center we have 40 or more budget discrete lines and we can't move money from one line to another or deploy dollars in one line for something other than what congress has described. So with this new funding opportunity announcement we have broad direction from congress how to prevent and control diabetes and heart disease and stroke through primary prevention activities. We have some guidance about working with state health departments. That's not a requirement so we're able to work with Indian country as well. We certainly did check in with our funder to make sure that was a correct understanding and they did agree with that. So we will look at the agency priorities in terms of how we craft that, and you heard earlier about the leading causes of death. I think Judy mentioned that in her presentation as one of the three strategic priorities, so that FOA will be closely aligned with that strategic priority. In terms of the Million Hearts initiative which Dr. Frieden described and the ABC's, aspirin,

blood pressure control, cholesterol control and smoking cessation, that is a broad partnership initiative and I'm not sure that we've thought about how we can really engage Indian country in Million Hearts so I will follow up because I think there's a tremendous amount of potential there that I'd like to learn more about and share with you as well.

Councilman Chester Antone: Thank you. Dr. Baldwin

Dr. Grant Balwin: Thank you for the question. As you probably know, there's been a fourfold increase in deaths as a nation from prescription drugs and as you've heard from Dr. Dellinger and Captain Billie yesterday it's now actually overtaken as a nation as the leading cause of injury death. One of the charges to Dr. Sawson, the new Injury Center Director, was to figure out a way to significantly enhance CDC's work in this area so we're repositioning the unintentional injury prevention assets to focus more in on prescription drug overdose prevention. Under Captain Billie's leadership we've invited some initial conversations with the Indian Health Service. It appears there's growing interest in collaboration on the prescription drug issue but would be happy to share some contact information after to connect specifically with you. Oregon has been among the leaders as the epidemic has taken hold in that state, as a state, in trying to tackle the problem. So would love to continue the conversation.

Councilman Chester Antone: Thank you. At this point I want to recognize Vice President Jim and then after Mr. Jim will be Lisa Pivec and I think that's gonna do it for this session.

Vice President Rex Lee Jim: Thank you Mr. Chairman and CDC leadership here, thank you. Tribal leaders. There are a few things I would like to address, not necessarily questions but possible suggestions and just comments for all of us to think about. One is what's this whole dialogue about? The ability to listen and to hear one another and listen. One example. I was going to address Dr. Frieden's comments but didn't get a chance this morning and the first thing he said to my question was I can't solve everything. I don't remember asking him to solve everything and I don't expect you to solve everything but we can solve certain things if we work together, and that means listening to one another and respecting one another. I think we need a paradigm shift here at CDC and even within indigenous communities and we need to take a look at this whole idea of scientific credibility. Who defines that, what does it mean? We know that western logic says if I throw a ball at the wall, it will only go halfway and then halfway and halfway and it will never hit that. But you know when you throw a ball it hits the wall. The other is my father, unfortunately, we lost him three years ago but he ended up in the hospital and they start giving him medicine of all kinds and drugs and so on, and he was becoming more and more a vegetable and so they told him that's the way he'll be for the rest of his life, we can't really do much for him other than to give him this

medicine. So just take him home. So we did and took him to a medicine man. We did certain ceremonies and then he said get rid of all the medicine that the doctors have been giving him. And we did. Two weeks later he was running around. A month later he was walking 12 miles down to Rockport store to get a can of Skull. Eighty years old. And we have many stories like this from Indian country where medicine people actually cure people where doctors fail. So what I'm asking is let us rethink about what we talk about, research, scientific integrity, evidence-based. There are other ways of knowing and other ways of healing. So when we talk about collaboration and working together, we need to take these other systems into account and accept them for what they are, a healing system, and it works. And so how do we find research or pilot programs that bring these two systems together to work together to learn from one another. I think that's important. We also know because of global warming and other things, those problems are created by the scientific community and research is beginning to indicate now they're looking to indigenous knowledge to help address some of those issues. So we do need to rethink some of those through and think about a paradigm shift and find a way to work together, and that is important. The other story I'd like to share is I read it somewhere; I don't remember where but I've always remembered this. There was this very strong person who was very generous and wants to help people. Standing by a river and all these people were floating by drowning and this person jumps in and saves some of them. Finally, someone recommended to him, why don't you go upstream and find out what's causing people to drown—and somebody was throwing people out there. So when he got rid of that person, then people stopped being drowned. I always think about that. So when we talk about better prevent leading causes of illness, think about those leading causes. What are some of those? And sometimes when you think about that, it doesn't really necessarily relate to illness, chronic illnesses. We talk about traditional foods and nutrition. So the question is how can you work with the Department of Agriculture and other agencies across the U.S. agencies and pull your resources together, work together and then involve Indian country and address these issues. We talk about the Navajo agriculture product industry and it's not even completely funded yet. So we're trying to find ways to allow Navajo chapters which are local political units to take some of that and plant, experiment with planting different types of food that they can reproduce in their own communities and find ways to empower people to start cultivating. We're working on that project. So CDC can help—if not help fund but advocate to other agencies and say this is what we're finding, these are the leading causes, if it's malnutrition, to prevent that you have to have nutritional food and traditional foods and so on and we strongly recommend funding that kind of work is important. And we talk about schools, Department of Education, how are we working with them pulling resources together to educate our young people. We know once they acquire certain habits, it's hard to undo that. So somebody said it starts in the womb. If we can begin early, early childhood, Head Start, teach them how to garden, learn about nutrition and so on but at the same time to have physical activity outside working the fields, I think that's important. And one of the things we talk about

is senior citizen centers next to Head Start so they can have forums and grandparents can re-teach young people how to plant, how to cultivate and prepare the foods, and there will be that engagement for the young children will not only be re-learning the language but the culture, values and so on from their grandparents. That intergenerational cohesiveness is so important in Indian country. So we need to begin to think outside the box and support some of these programs. The other thing I'm interested in is the power of the human brain, the role it plays in healing and preventing certain things from happening like suicide. What role does the human brain, all that study in neurology and how is that connected to faith, the human spirit and the role it plays, the power it has in healing. I read a book called *Stroke of Insight* by a Harvard Neurologist who had a stroke. It's such a wonderful story. I'm sitting thinking how can we educate our people to that level so if something like that happens, they can reconstruct their whole nervous system, their ability to heal themselves. So these are just some comments I'd like to make for all of us to start thinking about and start finding ways to bring a more holistic approach and to start working with other agencies within the U.S. and in Indian country as well. Thank you for allowing me to ramble on for a bit.

Chairman Chester Antone: Thank you Vice President Jim. And Lisa, I'll call you and then after Lisa I think that will do it for this session and we'll break after that.

Lisa Pivec: Thank you, Chairman. I just have a couple of comments and as I made my notes for all the different senior leadership that was here, I began to realize, Dr. Monroe, that everything I am talking about all relates back to public health readiness, public health accreditation and building of our infrastructure, so it was an opportunity for me to reiterate my statements from yesterday about the uniqueness of the funding to tribes for building public health infrastructure and what that means to us and our ability to not only utilize the funds we receive from CDC and other agencies well and more effectively but to also compete for those. And as you were talking about the funding opportunity agreements, one of the things having worked with CDC for 15 years with direct funding is that the building of the public health infrastructure is the one thing that can help ensure that you write a successful application, and I've seen that more and more as I've worked through this. Dr. Bauer, yesterday I didn't get a chance to respond but your question about funding, direct funding to tribes not to states or national organizations. One of the other things I wanted to mention is you asked about—and Dr. Frieden asked this morning about capitalizing on Indian country and what we do, and one of the things I've thought for quite some time is mentoring of other tribes that are within your area. If you have successful programs within CDC, a lot of times what I'm seeing is that money goes to national organizations to facilitate that mentoring and if you are not in close proximity geographically, you're not going to maximize that. I've seen that over and over again. We worked with CPPW and we had to mentor two tribes that were halfway across the United States. So we had phone calls which were not effective and we had a few trips. If we were able to mentor the people who are right next door to us, the

Chickasaw's, the Creek's, the Choctaw's and vice versa, I think we would have made much better use of those funds. And the last thing that I would say is that as I listened today it became clear to me that preparing for public health accreditation and looking at all of our domains, we have many areas where we don't need necessarily funding but we need your expert technical assistance in developing comprehensive plans. I see that as one of the biggest barriers to 1) us seeking and receiving funding because when the announcements come out, we don't have shovel-ready projects, and 2) we may not have the expertise to know exactly in different areas what we need to do and how we can strengthen our plans. So thank you.

Councilman Chester Antone: Thank you, Lisa. At this time I'll go ahead and say that we're done now with this session unless there's any burning issues. So as the practice has been the first day, we'll have Molly do a recap and then we'll go to lunch.

Molly Sauer: Okay, so we covered a lot today and we'll touch on some of the highlights that came up across all of the sessions. And again, as we did yesterday, if I missed anything, please remember that we are recording this session and we have several people taking notes so it's probably been captured but please feel free to come up and talk to me during lunch or during one of the breaks and we'll make sure the notes are updated here. Additionally, again, these are really just the things that have come up several times. There's been a lot of issues that were repeated so we've definitely gotten the message. First, this morning we talked about the cost of heart disease, stroke and diabetes and mechanisms to relay that cost as a way to really enforce the need for prevention rather than focusing on the clinical treatment side. We talked about needing to bring attention to the people behind the data and the communities that are behind all the numbers that we constantly are repeating and I wanted to highlight the quote that Dr. Frieden presented to us that we in public health are at our best when we see and help others see the faces and lives behind the numbers. We talked about utilizing tribal governments and specifically you all as tribal leaders to set an example and really lead the charge among your communities and making these changes and increasing prevention efforts. We talked about increasing collaboration between CDC and other federal agencies and others across the board such as tribal epi centers. We talked about the need to support data sharing and data access, and again, bringing up the epidemiology centers, ways that we can take the data that we have that is available and that others have and make sure everybody is able to use it to advance all of the efforts that have been discussed here. One of the questions that came up a few times was really how can we make a dent in health disparities whether it's one issue at a time or looking across the board to see where we have the opportunity to make an impact. One issue that came up, again, just like yesterday is the focus on traditional foods, traditional activities and that's across the board, not just in some of the chronic disease areas that we've talked about. We discussed other opportunities for collaboration specifically between tribes and universities and other academic institutions and ways to

create new infrastructure for educating the next generation and improving the systems that are in place for these public health prevention issues. We discussed, again Lisa, the uniqueness of funding for tribes and how we really need to look at it from a different perspective, highlighting how accreditation, when it comes to funding tribes, is really building infrastructure versus just enhancing what's already there. And, again, talking about the use of stories and particularly using those stories not just to educate but to take that up another level and advocate; go to your congress member and talk about how these projects and this funding is affecting your community as to how we can continue that and improve it. And then another highlight, we talked a lot about immunization coverage and I wanted to remind everybody that we are going to be talking about the VFC later today during our budget presentation this afternoon. So, again, there were a lot of other issues we covered. I have a lot of notes over here so please feel free to come up and we will make sure it's in there. Dr. Monroe?.

Dr. Judith Monroe: I just wanted to make sure you reminded everyone that 1:15 will be the tribal testimony.

Molly Sauer: Yes, and the tribal testimony, just like the rest of the meeting, is public so you're welcome to come listen and sit in the audience.

Councilman Chester Antone: Okay, 1:15 we start again. Thank you all.

END OF SESSION

Councilman Chester Antone: ...Make a few comments. I feel that the earlier discussion, the roundtable, was a very good one and I think we need to really start focusing on our engagement plan in order to address a number of those issues that were brought forth and begin to work towards addressing the how's, how we're going to do this, how we're going to collaborate all the work that lies ahead, and I just wanted to make a comment on that. Now I would like to call on Ileana Arias who is the Principal Deputy Director for CDC/ATSDR and she is going to be representing Dr. Frieden who is not here, and then I would like to call any senior leadership, CDC leadership to come up to the table if you might. I'm going to ask Ileana to perhaps say a few words and then I'll start recognizing folks around the table, the TAC membership, who want to provide testimony and I'll do that after your comments.

Dr. Ileana Arias: Thank you very much and good afternoon and welcome. I'm sorry I wasn't able to join you this morning but I'm glad to be here now. I know that you met with Dr. Frieden this morning. I assume that he gave you an overview or some information about our current priorities. I won't go over all of that just in case but if there are any questions about that, I'd be more than happy to answer them. What I would like

to say is, as I think probably was communicated, we are committed to doing the best we can for making sure we safeguard the safety and the health of every citizen of this country and not just in this country but abroad all over the world as well. We do that in a number of different ways. There are two things that are critical in our success to do that. Not only is it us developing the knowledge that needs to be implemented in order to address those health issues to make sure we make those significant impacts but all of that rests on the ability of us to be aware of what it is important that we need to address, what is it that communities are experiencing, what is it that their needs are, what their priorities are so that we can make sure that we are successful in helping them address those. What we know is that health is really a local issue kind of like politics and although we are a federal agency and have resources to be able to help, if it doesn't get implemented, if it doesn't get adopted at a local level, it doesn't matter how well spirited we are, it doesn't happen. So meetings like the one we're having here and others that we have with you on an ongoing basis become indispensable in terms of our ability to know what the needs are, what it is that you're in a position to be able to do on behalf of the health of your communities and then help us guide our work here so that we can empower you to actually have that kind of impact that we want you to have. So more than happy to have the opportunity then to continue to hear from you at this meeting and then after the meeting, again, on what those needs are and what are the things we can do in order to empower you to have the greatest possible impact.

Councilman Chester Antone: Thank you Ileana. Now we're going to get into the Tribal Consultation which is the most important part of this meeting today because this is when you hear from the tribal leaders about the concerns in their areas or any other concern they may have. So normally throughout the number of years that I've been here and other places, we present testimony for you, and some tribes have written testimony as well to submit but mainly that's what we do. We're not trying to address issues but it's mainly so the tribes can bring those issues to you, and then CDC can take it from there. So I'm going to ask Chairman Cadue to start us off.

Chairman Steve Cadue: Good afternoon. The agenda has called for tribal testimony. I'm Steve Cadue, I'm at-large delegate to the TAC committee. I'm not going to do the verbatim, I'm just going to highlight my testimony. This is my first meeting with the CDC TAC committee. I was very honored to be selected for this very challenging and responsible position. In the appointment letter from Dr. Judith Monroe.. I think was the signature on the selection letter, this was my first trip to the Centers for Disease Control headquarters. In the letter it says that the CDC is the largest public health agency in the world. And that it is. I'm just in a short time I'm just overwhelmed and very impressed with the mission, with what I'm seeing is the mission of the CDC and the structure here and the staff. This is the most respected public health agency in the world of the most powerful nation on earth. I've got a note that I have not heard any comments, and it's partly my fault probably for not contributing but there was no mention that I caught a

note of about our military veterans and the healthcare that we need to provide our military veterans. The CDC and other federal agencies are grounded in the treaty relationships, U.S. Constitution, U.S. Supreme Court decisions, and their obligation to Native American people. So while I recognize and certainly proud to be an American, and I myself am a military veteran, it is of course impressive of the CDC. But as a whole I represent a population of people that's got the lowest health condition of anyone in the United States of America. All the lands that the United States occupies and has control of today was once in the hands of our ancestors from border to border, coast to coast, and in many of our Indian treaties we seeded the territories and the land and have provided obligations of the United States of America. It's included—and it should be—it's included in all the literature about the establishment of the CDC and its purpose. In my report I've got the issue about the treaties and in particular the Kickapoo Tribe, the Kickapoo Nation. Now, for the CDC people that need to be aware, most are treaty, for example, I probably think most Indian treaties are referred to as nations in our treaties. Nations. And when you look back at those times of the original formation of America, treaties were made many times with Indian tribes to be at peace, to not have war between the United States and our Indian nations. For most people today that's probably hard to comprehend but it's in fact true. Indian tribes were at war with the beginning people of America. Why? Because it was our lands, it was our people, our homelands, our culture, our way of life. That's why. That's why we were at war. The highlight of my report is the federal responsibility, and I've said that the United States government has failed to live up to its trust responsibilities. Funding is insufficient. It always has been. In the original report that I gave the acting chairman here that's representing Dr. Frieden, I've attached the U.S. Commission on Civil Rights report, A Quiet Crisis—by Berry was the author of that and her committee and the United States Civil Rights commission. When you look at that and over all this time, I don't think there's been much improvement in Indian healthcare. This morning Dr. Frieden reported that there is another disparities report. I haven't seen it but it will be done I think in the next few days. An area that I highlight in my report is poverty. I'm convinced that if our economic conditions were better, we would vastly improve our health situation of Indian people. Yes, that's not a charge and responsibility of the CDC and it's a charge of other specific federal agencies and overall the federal government. Recently, President Obama formed a cabinet, sort of an Indian country cabinet of the secretaries of Native American issues, and they are supposed to meet regularly and collaborate. We use the word collaboration a lot in these meetings yesterday and today. We've asked these different secretaries to focus on the issue of poverty. If we can better improve the poverty, the economic condition of Native American people, we can do a lot to accomplish our own health improvement. The health status today. In Kansas the American Indian male dies on an average of 9.7 years earlier than white males. American Indian females die on an average of 9 years earlier than white females. We're not talking about statistics here. We're talking about human beings, our beloved people. Dr. Frieden opened up his presentation on some grim statistics this

morning. Diabetes, heart condition, high blood pressure, and he said they are killers. When you're killed, you're no more. You're gone from, at least from this earth. These diseases are killers. I would ask the CDC staff and directors to hear my word about that. Human beings. That's what we are. I'm talking about water climate change. It's a great issue that's unknown but it's real. In our case, we think it's contributing to the drought and the flood conditions of our homeland, and so are a lot of other things and I'm certainly not a scientist in that area but we believe that climate change, global warming is real and it's affecting the health. Water. Quality of water. I asked Dr. Frieden this morning when it went up on the board on the slide about what the CDC could do better. There are many, many things, of course, and it will take a lot of effective consultation. That's my word, effective consultation with Native American leaders in what and how we can participate and contribute to the improvement of the healthcare of Native American people. I want to say this. I'm truly impressed with the presenters from the CDC staff, the directors and Dr. Frieden on down. I'm going to put my friend here on the spot to my left. I just happened to be seated by him in this conference. You've been a great help to me. I told him this morning, I said I was very impressed, overwhelmed actually by the mission of the CDC. But I said, Bobby, is this skills and resources, is it getting out, is it being delivered to our Native American people? It is. Maybe to a great degree. To me, while I have to practice self determination, practice the management of tribal government, I don't see all of the resources reaching the ground where I work daily. But I know each one of you are going to dedicate yourselves to improving that condition. I'm convinced of that. Thank you.

Councilman Chester Antone: Thank you, Chairman Cadue. Cathy Abramson?

Director Cathy Abramson: Good afternoon. I'm Cathy Abramson and I'm glad I have this opportunity to speak with you this afternoon. For those of you who don't know me, I'd like to introduce myself and explain a little bit about my perspective that I bring with me today. I'm an elected tribal leader. I've been on our council for 18 years. That's 36 years of governmental years. Just kidding. And I'm the chairperson of the National Indian Health Board. In these two roles, I've had the opportunity to gain some insight to the State of Tribal Public Health in Michigan, the Bemidji area and Indian country more generally. By the way, I do represent the Bemidji area on this committee. My tribe is the Salt Ste. Marie Tribe, the Chippewa Indians. It's a 44,000 strong federally recognized Indian tribe that spans across the eastern upper peninsula of Michigan through Chippewa, Luce, Magna, Schoolcraft, Elger, Delta and Market counties. We are an economic force in the area and have housing and tribal centers, casinos and other enterprises that employ both natives and non-natives. The enterprises fund tribal programs and advance the goals of the tribe, has set out including being self sufficient, being good stewards of the land and waters, and being a force for good for surrounding communities. In terms of health and public health programs, the tribes health division

has seven health clinics or centers providing various levels of medical services throughout our seven county service area. Our health division's mission includes a strong emphasis on providing high quality care that is responsive and sensitive to cultural needs with an emphasis on disease prevention and health promotion. We very much value the public role health has to play. This role is especially important in the time of shrinking budgets. So now I'd like to take a little time to report on some of the most critical Bemidji area needs where I will add some observations and pressing needs on the national level where I can and then conclude with some recommendations for the federal agency action including CDC's action. The needs I will highlight come from a variety of sources including the 2010 community health data, data profile of Michigan, Minnesota and Wisconsin tribal communities completed by the Great Lakes Senior Tribal Epidemiology Center. Chronic disease. Diabetes. Diabetes is an important and pressing health issue for American Indian and Alaska Natives everywhere including the Bemidji area. It is the leading cause of death and disability and takes a heavy toll on individuals and their families. It also impacts communities in negative ways as treatment for diabetes accounts for a large percentage of health and disease-related expenditures. While diabetes is a challenge for many communities, it is an area of disparity that stands out for American Indians Alaska Natives. Statistics from a number of different sources point out this disparity. The prevalence of diabetes for American Indian Alaska Natives is more than twice that of U.S. adults overall. With this prevalence of diabetes we also see higher rates of cardiovascular disease, higher blood pressures and depression. This is true for the Bemidji area and also reflects what tribes across Indian country report. Maybe that long winter adds to the depression. I know that I felt a lot better as I left it yesterday. But maternal and child health. In the area of maternal-child health, American Indian Alaska people are people also suffer from dramatic health disparities. In the Bemidji area, infant mortality is higher for American Indian Alaska Native populations compared to the all races rates. SIDS. A disproportionate number of deaths occur due to Sudden Infant Death Syndrome in the American Indian population compared to all the races population. In fact, over two times as many American Indian Alaska Natives infants die from SIDS compared to the all race population. Because many risk factors for SIDS are controllable, all reducing commercial tobacco smoking and improving sleep environments, this disparity is one that is right for stepping up intervention in the form of increased outreach and education. Teen births. In the Bemidji area nationally, there are a greater percentage of births to teenage mothers of American Indian Alaska Natives as compared with the all race population. Both prevention and intervention efforts may be appropriate to address this disparity. Teen mothers are less likely to finish high school than girls who do not become pregnant during their teen years. Age is also an important consideration for a healthy pregnancy as young mothers do not seek prenatal care as soon as older mothers, are more likely to give birth prematurely or to low birth weight infants and may have more problems during the delivery. Smoking during pregnancy. Recent statistics underscore the need for smoking cessation programs, outreach and education for

pregnant women. In the Bemidji area those statistics show that approximately one-third of American Indian Alaska Native infants in the three-state area of Wisconsin, Minnesota and Michigan smoked during their pregnancies compared to the 13.6% of mothers of all races infants. Behavioral health commercial tobacco. For millennia American Indian Alaska Natives have used traditional tobacco as spiritual and physical medicine. In recent times, however, many people have taken up commercial tobacco. According to some accounts the prevalence of smoking for American Indian Alaska Native adults was more than 40%, well above any other racial or ethnic group. Commercial tobacco use causes serious damage to our health across Indian country and in the Bemidji area. In our area, we see some of the leading causes of death are cancer, lung cancer, and chronic lower respiratory disease. It is estimated that approximately 80% of chronic lower respiratory disease is caused by smoking. Again, this is an area ripe for stepped up prevention activities. Rather than treating people once they're sick we need to allocate the resources to ensure people never start smoking commercial tobacco in the first place. We also need to focus special attention on our youth and help them develop strong and healthy habits that will keep them from the disease. We need to involve our youth a lot. It's amazing the message they send and I will tell you this, and I use my husband as an example. He did smoke and my daughters were both very young, and said at one time when we tried to get him to smoke and we said what happens if he doesn't quit smoking. And the one said, well, if he doesn't quit smoking, he will die. What are we gonna do? And they said, well, we'll just get a new daddy. Well, he quit smoking and he hasn't smoked since. Anyway, it worked. And then another little boy came up to my brother who smoked and just looked at him and said, you're gonna die, because he was smoking a cigarette. And he no longer smokes. So there's a lot that our kids could teach our adults. Obesity. In the Bemidji area obesity and overweight is also a cause for concern. Recent statistics show that approximately 40% of the American Indian Alaska Native population is obese and 35% is overweight. These rates put our people at increased risk for obesity-related illness including coronary heart disease, stroke, high blood pressure, type II diabetes, cancer, sleep apnea, and respiratory problems, and the list continues. I have to tell you, my children are on my case now for losing weight. I do carry my tennis shoes and I am trying so I can get into a walking race at least with you. So recommendations. All of the areas I've mentioned, and the others mentioned by my colleagues here, are areas that we need to see a true and renewed commitment to action. As tribal leaders we are committed to meeting these challenges. Simply put, we will do whatever it takes. We ask our federal partners to do the same. As we often remind our federal partners, many years ago the federal government took on a trust responsibility in relation to the tribes. This role and this responsibility is evident in all the treaties signed by the many tribal nations. As it can be seen in Supreme Court cases, it is reaffirmed in legislation and in executive orders. It is a fact beyond questioning. All of this establishes the duty of the federal government to provide for the health and welfare of the tribes. This duty is not the province of one particular agency like Indian Health Service or the Bureau of Indian

Affairs. The duty to the tribes runs from the whole federal government to the tribes. While it is true that there are agencies that have been set up to fulfill this duty like IHS, it is also true that the duty has not been fulfilled. IHS is funded at approximately 56% of need. Because the federal government must meet its solemn obligations to the tribes it should; in fact, it must look at every other possible avenue to discharge its duty. In the area of public health, the federal government can and must respond to these urgent unmet needs with CDC resources. As a lead federal public health agency, CDC is both equipped and obligated to provide direct funding, training and technical assistance to the tribes to assist the tribes as they tackle the formidable public health challenges I've mentioned. Where funding is competitive, funding opportunities need to be written and evaluated so that tribes have a fair chance of winning awards. Funding all too often winds up far from the communities that need it most. Please remember that a community that experiences tremendous needs we see may be spending more time dealing with pressing public health needs than taking grant writing classes. Likewise, funding that goes to states often is allocated based upon data that includes the needs for American Indian Alaska Native populations. Unfortunately, that funding often does not make its way back to the tribes or does not return in anything close to fair proportion. Federal partners including CDC can increase the oversight they exercise over states receiving funding to ensure the funding is used as it was proposed. The CDC as the lead federal public health agency also has resources it can bring to bear to improve the data picture in Indian country. As mentioned before, data on American Indian Alaska Native populations is not always reliable, it is not comprehensive. Data reside in many different unconnected places. Data do not always capture American Indian Alaska Native status. Reporting does not always occur in small populations, tend to skew the data, over sampling often does not work. CDC can provide resources to allow tribes to successfully and comprehensively collect, use, store, share and protect American Indian Alaska Native data. These resources should include funding support, training and technical assistance. Having this comprehensive and reliable data will allow tribes to view a most accurate picture of need, develop and carry out targeted interventions and evaluate their efforts. These data also can demonstrate American Indian Alaska Native needs to those deciding funding priorities. Finally, I would suggest that all of the preceding requires sustained robust communications effort on the part of the agency. We often hear from federal partners that they want to engage the tribes, but this must be more than words. We need to see our federal partners reaching out and engaging in regular and meaningful consultation and collaboration with tribal officials in all matters that have tribal implications. Each federal agency and its operating divisions is responsible for strengthening the government-to-government relationship between the United States and Tribal Nations. To this end, CDC should make every effort to reach out to the tribes with every means available. We also hope that you will genuinely endeavor to meet communities where they are both literally and figuratively. If the needs of tribal communities are different from that of other communities, meet them where they are and tailor your response. Visit the tribes you

serve so you can understand their challenges and build trust. None of the measures I have outlined are quick and easy but they are the ways we can build the successful efforts of the past to make a healthier tomorrow. I'd just like to thank you for the opportunity and would like to invite you to the Bemidji area where we have the largest in the world the fresh water and it's very important that we keep it that way. We're supposed to drink water, at least eight glasses of good clean water a day and that's very important and we'd like y'all to come and see it sometime. Thank you.

Councilman Chester Antone: Thank you, Cathy. And next I have Mr. Gilbert and then after Mr. Gilbert will be Vice President Jim.

Tim Gilbert: Thank you, Mr. Chair. I guess I wanted to offer another thank you for all the CDC leadership and representation to take time out of their schedules to come and visit with us. I've said that before but I just realized that every one of you has a full plate and a full calendar and it means a lot that you would carve off the time to come visit with us. I have just three areas I'd like to offer as part of the formal consultation. I'm the authorized representative of the Portland area. The area representative, actually Councilwoman Shawna Gavin who couldn't be here and asked me to come in her place. I won't bore you too much with the details about the Portland area. I'm sure by now everybody is familiar with the different Indian Health Service areas, and if you google the northwest Portland area Indian Health Board, you'll get a really good overview of the tribes that we represent in the three-state area. I will share with you that I am with the Confederate Tribes of the Umatilla Indian Reservation as the CEO of the Yellowhawk Tribal Health Center that serves the needs of those confederated tribes, and we are a treaty tribe, and you've heard that maybe mentioned in different ways before either using the words tribal sovereignty or treaty tribes and federal obligation. And I won't go into detail about that now but I would encourage you if you're on that side of the table if you're a CDC staff person and maybe new to Indian country or unfamiliar with what some of those words mean, it may be worth going to google them as well. Those words have a lot of power and a lot of meaning to the tribes that we come from and the responsibilities that we feel like the federal government has to address health issues. So I would just encourage you, if those words aren't resonating with you, to go look them up. I feel like I've been blessed with the opportunity just to share throughout the last day and a half—maybe it wasn't formal testimony as we're doing now but I appreciate the opportunity to provide some insight when different department heads or managers or leadership shared on their department. So those were maybe a bit more in the weeds discussions as we were talking about specific disease topics or programs so my comments during this next couple of minutes are I hope more kind of 30,000 foot perspective. And I will share, just in case my boss is on the line, that I have consulted with her, and as it turns out texting has a role in consultation, so thank goodness for technology. The first one is something you've heard for the last day and a half and that is, number one is just continue to help us address our disparities. It's been said in

different ways by each one of us here, and I won't even try to identify what those disparities are. In some cases you have identified them. I will tell you that Shawna asked me to make sure I mention the importance to our region of elder health and diabetes and I think you've also heard concerns about that in the last day and a half. But I guess what I would say different is that it feels to me that we're in an age and a period of technology where we should be able to measure those things that are disparities. It was brought up during the opening comments of this Tribal Consultation Meeting that this is the 10th Consultation Meeting. There was a first. There will be 110th I hope. And if we were to have—I guess I'm envisioning in my mind—a dashboard so to speak of the disparities that this group might help to identify, if we would've had that dashboard developed in the beginning and are looking at it today at this meeting and looking at it at the 110th meeting, we would hopefully be able to demonstrate some measurable impact on those disparities. And if we're not, then we should rethink how we're going all this because if we're not making a difference in those disease prevalence rates or incidents of disease, then what are we doing here? So I'd ask that maybe give some thought—I don't know if that's OSTLTS or who that is but give some thought to a dashboard that we could pay attention to ongoing to make sure all of our dialog is making a difference in terms of actual outcomes. Number two has to do with the resources that address those disparities. I said this yesterday I believe in a more abbreviated way. The resources—I think all of us mainly think of resources in terms of cooperative agreements or funds that are directed towards tribes that will help us address the disparities that we just discussed, but that doesn't always mean money. Even in my little corner of the world, the frontline, money doesn't always address a problem. It could mean other resources, and Dr. Monroe showed a slide during her presentation that showed different people out of different departments that came and provide some kind of technical assistance to tribes. That's a resource. My point is that to accomplish number one that I mentioned, it doesn't feel like we're going to make too much headway this week and move the dot on the amount and the type of resources that comes from the CDC to tribes. So if you could flash back to that dashboard again, if we have the disparities identified and we're able to measure them, I would appreciate being able to know the level of resources that come to tribes when we have these types of meetings. Is the amount different from the first meeting to the 10th to the 110th. Would be really appreciative to see if the resources are following the dialog. So that's number two. Number three—Cathy mentioned it before I did but it's really ongoing meaningful consultation. As I said before, this particular meeting has felt genuine to me. It's felt like the people have shared information aren't doing so under a mandate that they actually have a sincere desire to share with us the good work that they're doing that tribes benefit from and that's really appreciated. So the meaningful part is that you're coming to us with an open mind and sharing the resources and the help that you've provided to us and looking for some guidance maybe from a tribal perspective. But that's a two-way street. I believe consultation isn't a one-way avenue. I have the responsibility to bring you information from my little corner of the world that maybe helps

as you develop policy and develop RFP's and help us address our disparities. So I have the responsibility to go back home and make sure I can come to this table in the best way possible to have that meaningful two-way dialog that's consultation. And I guess the caveat I'd put on there is that I mentioned ongoing. I had the pleasure of having lunch with the Hopi Chairman Herman Honanie and we were talking a little bit about comparing local politics, and things change in our world and things change in your world, and maybe you'll have a different director in three years or five years or whatever. But we would hope that the notion of meaningful ongoing consultations sticks around despite who's in the director chair that that two-way dialog will continue. The last thing I guess I would say, two last things is, you know, we really need champions in Indian country if we're going to make any kind of dent in our disparities. I'll bring up an example. There are several you could draw from but I'm always reminded of a former Indian Health Service employee that kind of jumped over to the SAMHSA world and became if not the SAMHSA administration—and somebody correct me if I'm wrong, but a fellow by the name of Eric Broderick kind of converted from Indian Health Service he was a dentist for many years and went over to a leadership position in SAMHSA, and he of course took with him his belief in Indian health and the commitment to do good things and that was exemplified in the amount of resources that started to come out of SAMHSA directed at tribes and mental health disparities in Indian country. He'd been a champion on one side of the aisle and jumped over and it was a measurable difference in the assistance that came out of SAMHSA as a result of him being a champion in that new role. And I'm a firm believer that that's what we need on this campus. I'm awestruck by the amount of resources that you have and I also have a footnote in my head from this morning as some of your colleagues were discussing small budgets. I think we need to get on the same page about definitions of budget size, but I understand that not all of you will become champions because you have other priorities, other interests or other pressures but I truly believe we won't truly get where we need to be unless we have those kind of people who are really advocating on the inside of agencies such as the CDC. And finally, I'll just kind of echo again something Cathy had said that I believe that if you haven't been to Indian country, whether it's Bemidji or Portland or Aberdeen, wherever it might be, that you'll get an eye opening experience to come and see for yourself some of the challenges we face in the delivery of healthcare and addressing public health issues. So I would extend the invitation as well to come to the Portland area. Of course, Umatilla and Yellowhawk is at the center of the universe so please feel free to write that down and come visit at the right time of year. Again, I thank you for the opportunity just to share a little bit and that's all I have Mr. Chair.

Councilman Chester Antone: Thank you, Tim, and I'll call on Mr. Rex Lee Jim.

Vice President Rex Lee Jim: Thank you, Mr. Chairman. Honorable tribal leaders, distinguished officials and guests, I'm Rex Lee Jim, Vice President of Navajo Nation. It is my honor and responsibility to represent the Navajo Nation at this official tribal

consultation session to share testimony on several accomplishments, critical concerns and to provide recommendations that specifically pertains to Centers for Disease Control and Agency on Toxic Substance and Disease Registry. We ask that you also share this message with the Honorable Secretary Sebelius and your federal sister agencies. I'm accompanied by Ms. Ramona Antone-Nez. She is the Director of the Navajo Epidemiology Center. She also represents the Navajo Division of Health and is a CDC/ATSDR Navajo Nation authorized representative. On the Navajo nation we are building our public health infrastructure to establish a state-like Medicaid system, medical school and cancer institute. These are major initiatives requiring funding, strategic planning, technical assistance, capacity building and workforce competency development. In preparing for these major initiatives the Navajo Nation Division of Health has developed a legislation to become a department of health. Upon Navajo Nation Council approval, the Navajo Department of Health will be authorized to monitor, enforce, regulate, evaluate and monitor and coordinate public health system. We recognize the need to research and prioritize our highest public health concerns. These include A) injury prevention with child safety seats, no texting while driving; B) communicable diseases, HIV, STD's, GD, chlamydia and TB; C) mental health; D) alcohol and substance abuse; E) co-morbidities; F) chronic diseases, obesity, diabetes and hypertension; G) public health emergency preparedness and response; H) building a collaborative public health system. The Navajo Nation's government-to-government relationship with the U.S. is essential to access federal funds, access technical assistance to evidence-based practices, disease prevention, epidemiological investigation, strengthening our public health infrastructure and emergency preparedness. One, the Navajo Nation continues to advocate for the option to receive direct funding from CDC/ATSDR, to expedite implementation of funds rather than establishing a contract with the state. Two, it is important for the Navajo Epidemiology Center as a public health authority to access federal agencies for health data from DHHS specific, to birth, morbidity, infectious disease, disability, chronic diseases and mortality data. Data access is key to effective intervention programs. Three, the Navajo Nation needs to establish a specific disease surveillance system, infectious disease, Rocky Mountain Spotted Fever, West Nile Virus, Hunter Virus, chronic diseases, injury, disability to generate epidemiological reports. Four, the Navajo Nation Veterinary and Livestock Programs reports regarding several samples were sent to the CDC for testing on July 23, 2012, and we remain very interested in learning end results of the status of our request on the dog serology. This is extremely important to Navajo as this will determine if puppies vaccinated for rabies are protected which eventually protects our Navajo people. Five, requesting a CDC field assignee epidemiologist public health associate to be posted at the Navajo Nation to assist building effective health surveillance systems. Six, we appreciate the CDC's assistance with two epi aids during 2013 calendar year. One is the March 2013 concerning an increase in invasive group A streptococcal diseases. Two is the July 2013 comprehensive assessment to the availability of healthy food options. Thank you for your assistance, we appreciate it.

Seven, research such as the Navajo Birth Cohort study which was funded for three years, September 2010 to August 2013 through a cooperative agreement. We advocate for a longer term study on the effects of uranium contamination exposure and environmental health cleanup efforts. And related to this is water issues. A lot of our underground water has been contaminated by uranium. Eight, the Navajo Nation believes and recommends that adequate staff training is integral to collecting accurate data and effective health promotion and disease prevention. It is essential to design an evaluation plan to establish purposeful epidemiological surveillance to establish sustainability after the Navajo Birth Cohort study is complete. Therefore, the Navajo Nation recommends to ATSDR to provide additional funding to support a position such as an epidemiologist, statistician, data manager or demographer to be stationed at the Navajo Epidemiology Center. Nine, Navajo health education. The HIV prevention staff requires additional support from the CDC to achieve the following objectives. One, reduce the number of new infections by increasing the number of people who know their HIV status. Two, link patients into care and improve health outcomes. Three, reducing HIV-related health disparities. And four, develop a disease surveillance. And five, increase collaboration across agencies. And ten, the National Native American AIDS Prevention Center in Denver, Colorado cites CDC 2013 summary of notifiable disease MMWR 2013, Vol. 6, number 353 table 5 in 2011. American Indian Alaska Natives in general were twice as likely to develop a case of Hepatitis C as compared to the white population. American Indian/Alaska Native women were 1.6 times as likely to die from viral Hepatitis as compared to non Hispanic whites. There is a need for increase in funding to support Hepatitis C testing and counseling. A particular vulnerable population is the Veterans associated to age and timing of national vaccines of older people affects Hepatitis C. The native women are the third highest group to contract HIV. Native women overall environment is high risk for domestic violence, substance abuse, sexual assaults and human trafficking. HIV prevention such as HIV 101 is a valuable resource to target one specific virus. And finally, we have recommendations and our conclusion. The Navajo Nation offers the following recommendations to address and resolve our health disparities and concerns. One, the CDC and ATSDR provide funding directly to tribes in order to streamline funding processes and minimize the time it takes to receive and expend approved funds. Information was shared with TAC that this recommendation is a congressional process. Therefore, I respectfully request technical assistance on procedures in order to process tribal requests to congress. Two, allocate funding to generate collaboration between western traditional medicine to investigate the effectiveness when patients access both systems of treatment and prevention. Three, the tribal epidemiology centers must have direct access to tribal health data from federal agencies such as the Indian Health Service and CDC state and local sources. Four, the CDC needs to consolidate all infectious communicable disease funding, technical assistance, manpower and other resources for tribes such as HIV/AIDS, TB and STD. Five, the CDC needs to increase and expand support for chronic diseases such as cancer, diabetes, obesity and

cardiovascular disease including cancer screening, wellness, obesity control and education and screening for diabetes, and screening and education for LDL, blood pressure, and obesity for cardiovascular disease. Six, the Navajo Nation recommends adequate staff training be integral to collecting accurate data and effective health promotion and disease prevention. It is essential to design an evaluation plan to establish purposeful epidemiological surveillance to establish sustainability after the Navajo Birth Cohort study is complete. Seven, the Navajo Nation recommends to ATSDR to provide additional funding to support a position such as an epidemiologist, a statistician, data manager, demographer and health educators. Eight, the ATSDR tribal environmental think tank to provide recommendations to the CDC/ATSDR TAC as the formal tribal consultation. And nine, address the Urban American Indian Alaska Native health needs for health education and promotion through funding allocations. Ten, as unintentional injuries are the leading cause of mortality on the Navajo Nation we recommend an increase of funding allocations from 2% to 3% for the injury prevention programs. Eleven, consult among HHS HR departmental agencies. In closing, we ask for and look forward to your written response. We also would like to express our deep appreciation to the CDC's ATSDR and Office for State Tribal...

Councilman Antone: Before we begin this session, I have a reminder to please silence your electronic devices. We had some ringing going on in the last session so I need to remind you of that. So now, we're going to into the CDC budget and resource allocation for tribes update. And this will be done by Sallie Morse, Melinda Wharton and Kirsten Pope. And I'm going to turn it over to you.

Sallie Morse: Good afternoon, everybody. I'm Sallie Morse, the CDC budget officer and first I want to thank the Tribal Advisory Committee and Dr. Monroe for inviting me to come make this presentation for you. I'm happy to join you today to discuss how CDC's appropriations were used in fiscal year 2013 to improve American Indian and Alaskan Native public health. With me today are Captain Melinda Wharton and Kirsten Pope from the National Center for Immunization and Respiratory Diseases. They're here to discuss how the vaccines for children, the VFC program resources benefit AI/AN's. Let me start with just a few words about me. I've been involved in federal budgeting for over 30 years in various federal agencies, but I've only been at CDC for four and a half months. So, and this is my first experience in a public health mission. Just prior to this, I was the deputy budget director at the National Science Foundation and before that, the associate budget director at the Smithsonian Institution, where I was thrilled I played a big role in helping to open up the National Museum of the American Indian. So I'm pleased to have this opportunity today to join with you today. When I was at the National Science Foundation, one of the first briefings that I gave was to one of, I suppose a close counterpart to you, the National, the American Indian Higher Education Consortium. So I'm interested at learning about what the differences are and how both

of the organizations operate. The information I'll be presenting today represents actual fiscal year 2013 funding data. As Dr. Frieden pointed out this morning, I want you to keep in mind that all federal agency funding levels, including the CDC were impacted by the sequestration order last fiscal year. Under the sequester, CDC was required to reduce all discretionary programs, projects and activities by five percent. However, the VFC program was exempted from the sequester and thankfully, there are no follow on discretionary sequestration orders for this fiscal year. This slide describes the methodology that we used to report CDC/ATSDR funding for tribal public health and related activities. There are three components of AI/AN funding. The first are financial assistance awarded through grants and cooperative agreements to the federally recognized AI/AN organizations or public health entities. The second category is funding awarded through a contract to an AI/AN owned company or organization. And the third component are the vaccines purchased through the VFC program with benefit to the AI/AN community and population. For your information, we used a combination of data systems and sources to compile the information including the amounts reported on www.USAspending.gov and our internal grants and internal contract systems. Once we had the figures compiled, we reached out to the program sponsors of these funding information to validate the information. Based on your past feedback, we adjusted our grant reporting approach this year. This year we have categorized grants as both direct and indirect. Direct grant funding covers awards made directly to a federally recognized tribe, while indirect grant funding includes awards made to tribally designated or non-tribal entities for activities related to public health. This slide provides you an overview of total funding to AI/AN. In FY'13, CDC funded a total of \$223.7 million worth of grants, contracts and VFC vaccines with impact on the AI/AN communities. In spite of sequestration, the 2013 funding level of 223.7 is slightly up by approximately \$1 million or 0.4 percent from the prior year, FY'2012 level of \$223 million. By far, the largest component is the VFC funding, which accounted for nearly \$164 million or almost three-quarters of the total CDC funding. For comparison, VFC funding was only \$159 million in 2012. So 2103 is up three percent. Grant awards, both indirect and direct total \$28.5 million and represented 13 percent of all AI/AN funding. In comparison, 2012 funding was about flat at \$28 million. So there was really no change there. Contracts totaled \$31.4 million in 2013 or 14 percent of the total. Contract funding is the one area where we've noted a decrease year of year. This funding dropped by \$5 million and we believe that this was likely an impact and casualty of the sequestration. I'm going to now move on and focus on the funding for contracts and grants. So I will, most of the rest of my slides will be exclusive of VFC. So in FY'2013, CDC awarded a total of just under \$60 million to support AI/AN public health and related activities. Over half, or 52 percent and \$31.4 million were contract awards. There were 23 separate awards to tribally owned entity recipients. 48 percent, or \$28.5 million were grant and cooperative agreement awards to 73 native serving entities. As I mentioned before, we've been able to tease out the difference of direct and indirect grants. And in FY'13, the direct grants totaled \$8.8 million, which represented slightly less than a third. And indirect grants were \$19.6

million, or 69 percent. This slide compares the FY'12 and '13 funding levels. Just as a recap, our total FY'13 funding, including VFC was approximately \$1 million higher than it was the previous year, which shows strong support when you remember overall that CDC programs were hit with a five percent across the board sequestration reduction. As I mentioned earlier, contract funding is down about \$5 million. It's a 14 percent drop from FY'12 but grant funding is up \$1 million, or plus four percent from the prior year. This funding pattern generally reflects how CDC programs accommodated the sequestration reductions in each of their program areas. Next, I'm going to peel back the skin of the onion and drill down into contract and grant funding. This slide focuses on the contract funding. In 2013, we made 23 awards to AI/AN designated companies totaling \$31.4 million. 88 percent of these funds were awarded by four CDC centers and offices. The National Center for Immunization and Respiratory Diseases accounted for 28% of the total. The Office of Safety, Security and Asset Management, which is OSSAM on this chart, accounted for 25% of the total. A good portion of these funds were contracts to support facilities, repairs and improvements to give you an idea. The National Institute for Occupational Safety and Health, NIOSH, and the National Center for Emerging and Zoonotic Infectious Diseases both awarded \$5.5 million in contracts to AI/AN organizations. Now, let's move on to some details on the grant funding. In fiscal year 2013, there were 73 grant and cooperative agreement awards totaling \$28.5 million across nine CDC centers and officers. The National Center for Chronic Disease Prevention and Health Promotion funded the bulk of these grants, generally almost three-quarters of the total, totaling \$21 million. I'll provide a little more detail on chronic programs on the next slide. The remaining 26 percent of grant funding is shown on this slide. The Office of State, Tribal, Local and Territorial Support funded over \$3 million worth of grants, including a \$787,000 award to the Cherokee Nation to strengthen public health infrastructure for improved health outcome. And earlier this morning, there was a slide that also showed this same amount. The chronic program funded by far the largest amount of AI/AN grants totaling \$21 million. 60 percent of these grants funded cancer related activities. 10 percent of the award value funded diabetes health activities and 14 percent funded community transformation grants, or CTGs. Last year, in 2013, almost \$3 million of the grants were awarded to AI/AN organizations for CTGs. And I'm sure most of you probably know that in the 2014 appropriations, Congress eliminated funding for the CTGs. But they did establish a new \$80 million community prevention grants program. We're not sure how this is all going to play out at this point. We're still in the planning phases. This is a new series of slides that we are introducing this year, based on your feedback from last year. And this slide highlights how the \$28.5 million of grants and cooperative agreements awards were funded by Indian Health Service areas. The top three Indian Health Service areas receiving CDC grant funding in 2013 were the Alaska area, which received 28 percent. Oklahoma area at 17 percent and Portland at 16 percent. This is the same type of slide, but it shows contract funding and how contract funds were distributed across the health service areas. In 2013, three Indian Health Service areas received significant contract awards. Tribally owned, or Native

American owned companies in Alaska were awarded the highest value of these contracts, of 68 percent of the total, or \$21.3 million. They were followed by the Oklahoma service area, which was awarded \$4.2 million or 13 percent of the funds, and the Nashville service area was awarded \$5.7 million or 18 percent of the funds. This slide shows the approximate locations of direct and indirect grant and cooperative agreement awards. The red dots show the direct grants, and I'll remind you, of the total grants, direct grants represented \$8.8 million and the green dots reflect the indirect grants of \$19.6 million. There's your green dots. And there's the total picture. So, my part of the presentation is just about over, but we added this slide because I think we all recognize that enhancing AI/AN competitiveness in preparing grant proposals is key, is one of the key factors in increasing overall CDC funding. And these are two new activities that we wanted to share with you. One is a grant writing training program for tribal applicants. It is run by Dr. June Strickland, with the University of Washington School of Nursing. And this provides a series of online lectures on proposal training focused on AI/AN. And if you're not familiar with it, this website and it is in your books, is how you get access to those programs. And then secondly, CDC has recently standardized the format for our funding opportunity announcements for research and non-research solicitations. And one of the objectives here was to optimize our entire grants process and by improving the design for our FOAs, it would help you and help others prepare more focused competitive grant proposals. So if in the interest of time and nobody has any specific questions for me right now, what I'd like to do is turn this over to CAPT Wharton and Kirsten to address the VFC funding. And then we can come back and do any questions at that time.

Councilman Antone: Before we go, I have a question from Tim Gilbert.

Tim Gilbert: Hi, thanks for the presentation. Just a quick question. On one of your slides, you referred to native serving organizations. Is that easily characterized or defined, or what's the best way to think of those?

Sallie Morse: I would probably need to turn to somebody in the room to answer that question. If not, I'll get back to you. I'm still so new to CDC, I don't want to say the wrong thing.

Dr. Ursula Bauer: So I ask myself the same question. And so I looked at some of the names of the Indian serving organizations that fall into our grant portfolio. So that would be an example. The Indian Nation Council of Governments would be a Native serving organization. South Central Foundation of Alaska, let's see, Great Plains Tribal Chairman's Health Board. So organizations that bring tribes together and then serve in that way.

Sallie Morse: Thank you.

Councilman Antone: I just wanted to ask about the contracts. I noticed Tucson and Phoenix area weren't awarded anything. It says no funds on there. Exactly what are these contracts?

Sallie Morse: So in the briefing, your briefing material, we have appendices, let's get to them, which list each individual grant and contract. So you were asking about contracts. Obviously, there's more grants. Here, we do not necessarily state the state. But are you looking for a particular award?

Councilman Antone: I'm just asking really what those contracts usually fund.

Sallie Morse: So the contracts fund a lot of administrative support such as security services, buildings facilities and maintenance. Those are primarily funded by the, I'm going to my grants, by NCIRD. One of their contracts is to Chenega Total Asset Protection for security services. The OSSAM contract is for facilities, repairs and improvement. The NIOSH contract, again, is for building service support, and the Emerging and Zoonotic Infectious Disease contract is for antimicrobial resistance work and projects. So those are the examples that I was prepared to point out.

Councilman Antone: Ok. Thank you.

Sallie Morse: You're welcome. Okay. We can move on to VFC.

Melinda Wharton: Thank you very much. I'm Melinda Wharton from the National Center for Immunization and Respiratory Diseases and I'm the director of the Immunization Services Division. The Immunization Services Division is the part of the National Center for Immunization and Respiratory Diseases that actually runs the Vaccines For Children program. And this is really one of the flagship public health programs in the United States in where it's very important for child health in the United States and of course, the American Indian/Alaskan Native populations are a unique population within the VFC program because according to statute, all children in that group are eligible for the program. So it's particularly an honor for me to have a chance to talk to this group today about how the VFC program works. I'm going to provide just a little bit of history at the beginning to explain how the program was, or the impetus for the program. In the late 1980s, there were very large measles outbreaks in the United States. These were predominantly in urban areas and most of the children affected were young children. These were children who were too young to be in school yet and a lot of the children affected by these outbreaks were children in poor families, or were children who were members of racial or ethnic minorities in the United States. And what this outbreak did was really highlight some of the gaps in our ability to provide medical services to all of the children in the United States. And what this slide shows is some survey data that

showed that during the 1980s, there was in this particular survey an increase in the number of both family physicians and pediatricians who were seeing children for medical care in their private practices but were referring those children to health departments for immunization. So the children had a doctor, they were being seen for medical care, but those physicians were not vaccinating the children. They were referring them to the health department. And of course, when that happens, we're always concerned that the follow up won't happen, that the child won't end up at the health department and the child will remain unvaccinated. And indeed, what studies found when we started trying to identify the root causes of the unvaccination that led this large outbreak to occur, was that children were being seen by doctors, but vaccines weren't being given. There were missed opportunities for vaccination of children who had a doctor, they were being seen by physicians, but the vaccines weren't being given. And in recognition of that, one of the recommendations that came out of the measles outbreak was a recommendation to provide federally purchased vaccine for children who were part of the Medicaid program, so that there would not be financial barriers on the part of providers to providing vaccines to those children. And that resulted in federal legislation in 1993 which created the Vaccines For Children program. At the time the program was created, of course, this was back before there were so many vaccines that were routinely recommended for children. There were many fewer and if you look at the early 1990s, there were only a few vaccines and they were expensive vaccines. But since then, we have the benefit in the United States of the development of many new vaccines that can prevent many diseases that are really important in the United States. Diseases like Haemophilus influenza type B and invasive pneumococcal disease, which we know disproportionately have impacted American Indian Alaskan Native populations. So we've had many new vaccines that have been added to our immunization schedule and with that, the overall amount of funding that goes into the VFC program to provide these vaccines for VFC eligible children has increased pretty dramatically. And the reason for that, the reason for the big increase in VFC vaccine purchase is that there's more vaccines that are covered by the program and those vaccines are more expensive. So a little bit about the VFC program. The way the program was written, then children who are eligible for the program are entitled to receive these vaccines at no cost for the vaccine. And the budget process is a, it's a different one rather than our annual appropriation where there's an appropriations process with Congress and OMB and we get a budget. This is really a negotiated process that was based on an estimate of how much funding is needed for vaccine. And the decision about including a vaccine in the VFC program is really based on that recommendation from the Advisory Committee on Immunization Practices. Congress wanted public health and medical experts to make the decisions about what should be included, not budget people or administrators. They wanted public health people to make these decisions in the best interest of health in the United States. So they're the authority to include vaccines. And the way the program is run, it's basically that providers who participate in the VFC program are supposed to do screening. They're

supposed to determine whether or not children are eligible. And if, based on the answers to the screening questions, the child is found to be eligible, that provider can use the VFC vaccine to vaccinate that child. And they're not required to verify answers. So if the child, if the family doesn't have insurance, if the child is eligible for Medicaid, if the child is American Indian or Alaskan Native, that child is eligible for the VFC program. The providers who participate in the VFC program get, can order the vaccine and receive it from a centralized distributor without having to pay for the vaccine without having to file for reimbursement. It's not a reimbursement program. But they do need to screen for program eligibility. So this slide identifies which children, according to the VFC legislation are entitled to receive VFC vaccine through the VFC program. And it's for children up through 18 years of age, so up until their 19th birthday, you are eligible for Medicaid programs, are uninsured, are American Indian/Alaskan Native, as I said. And also, certain children who have insurance that doesn't cover vaccines can receive VFC vaccine at certain facilities at federally qualified health centers or rural health centers. That probably is much less of an issue than it used to be because insurance coverage for vaccines is now better than it used to be as the provisions to the Affordable Care Act are implemented. And currently, about 48% of young children in the United States meet one or more of these criteria for eligibility for the VFC program. So this pie chart shows for the children in the United States, which one are eligible for VFC and what is the basis of the eligibility. So the biggest group are the children who are Medicaid eligible which are the red part of the pie chart. About two percent are children who are American Indian/Alaskan Native. There's a group of children who are uninsured who are the purple slice of the pie. And then the small blue slice are those remaining under insured children according to our 2013 survey. And 51 percent of children are not eligible. So how does the program work? Well, the way the program was designed, it's a public private partnership with shared responsibility between public health and the providers who participate in the program. The vast majority of whom are in private practice. They don't work for the government. They don't work in health departments. They are practicing physicians who have applied and been approved to participate in the VFC program. So in order to make the program work, we ask public health departments to enroll VFC providers, to identify practices and get them signed up for the program, to come up with estimates of the entitled population in their jurisdiction, to provide technical assistance to VFC providers and assure proper implementation of program. And that includes everything from monitoring and assuring appropriate storage and handling, appropriate use of good immunization practice, the correct Vaccine Information Sheets, correct vaccine administration, as well as proper screening and accountability for vaccine. The providers who participate in the program, again the vast majority of whom are in the private sector, determine program eligibility at the point of service. So they need to ask those screening questions. They need to provide vaccines in accordance with good standard of care. They are required to provide all specialty appropriate VFC vaccines, so a pediatrician would need to provide all the vaccines that are recommended for children through age 18. But for example, if an

obstetrician gynecologist was a VFC provider, they wouldn't have to provide early childhood vaccines. They could only provide in their office the vaccines that are recommended for the age group that they serve. The participating providers can bill Medicaid for an administration fee and they can bill parents of non-Medicaid eligible children for an administration fee, but they cannot turn that family away if the parent cannot pay an administration fee. There's also responsibilities that we have here at CDC where we're responsible for overall program responsibility and stewardship. We make policies and develop policy guidances and we deal with a lot of budget issues around estimates of how much vaccine is needed and vaccine contracts. We also provide technical assistance to the awardees who run the program at the state and some local levels. We have contracts with vaccine manufacturers to purchase the vaccine and there's a lot of vaccine management activities that come with that including managing vaccines in times of shortage and predicting and monitoring usage. There's the vast majority of the funding for the VFC program goes for vaccine purchase, but there is a small amount of money that goes to support operations. And this supports these activities. There is some funding directly to awardees to cover program operations expenses which are day-to-day VFC program activities. There are some funds to look at vaccine coverages in provider offices to help support site visits, to do those assessments. There's a little bit of support for vaccine ordering and for vaccine distribution. But again, this is a very small amount of money compared to the overall supporting vaccine purchase and the amount of funds that VFC provides for operations is not at all sufficient to cover all of those activities that I had on previous slide that public health departments have to do to support the VFC program. And this is based in, so the funds that CDC provides through the discretionary 317 program also help support the VFC program. So in terms of what are the kinds of activities that the VFC operations activities support. Well, it would help support recruiting and maintaining a network of VFC providers so that children have access to immunization services. There's responsibility around program stewardship and accountability. There's assessment of VFC program performance in terms of again, going into offices and actually determining, have children been appropriately screened and have children received recommended vaccines that they should have gotten at given visits. And also there's been support for state and local immunization information systems to help provide that consolidated immunization record that's so improving VFC program accountability. There's currently about 45,000 provider sites participating in the program. There's many more providers than that because of course, many of these are multi-provider practices, but three-quarters are in the private sector. And these VFC providers range from solo practitioners to very large group practices to large managed care organizations. And collectively the providers who participate in the VFC program vaccinate 90 percent of the children in the United States. Some of them through the VFC program and otherwise through their private purchase of vaccine. Next, I want to show you a little bit of our, a little bit of data. This graph shows the portion of young people in different race ethnic groups who are eligible for the VFC program by race and

ethnicity and it ranges from 100 percent for the American Indian/Alaskan Native on the left. In both the young children, the 19 to 35 month olds as well as the teens, based on statute, to smaller proportions in other groups. This graph shows vaccine coverage for the United States for the period 1944 when the VFC program began through 2012, which is our most recent year for which we have coverage data through the National Immunization Survey. And this report's coverage for individual vaccines at 19 to 35 months of age. There's a lot of detail on this that I won't get into but there's two things I want you to observe. That is there's an awful lot of lines clustered at the top, right around 90 percent. And what that means is that for most of the vaccines, we have high stable coverage at the national level. And that's a really good thing. That reflects the good job that providers are doing in vaccinating young children in this country. The other thing to notice is that for the lines that start after, in '94 or later, where you see a sort of rapid rise. And what that indicates is the update of new vaccines as they're added to the schedule. So we do a pretty good job with young children of getting high coverage over five or seven or eight years following vaccine introduction that we tend to achieve high coverage. There is one line towards the right where there's a deep drop and then it recovers. And that's where we had a national shortage of Hib vaccine which was a very serious shortage due to a manufacturing problem that one provider had. And that is a vaccine which is used preferentially in American Indian/Alaskan Native populations because the pharmacokinetics of the vaccine lead it to provide quicker protection following the first dose. And because these populations are at high risk for this disease, we were glad we had a vaccine stockpile and were able to continue to provide that particular product during the shortage. The shortage is now better and so the coverage is now higher than what it was. This graph shows coverage for individual vaccines among young children by race, ethnicity and the American Indian/Alaskan Native population is the green bar, which is the fourth one in each of these clusters of bars. And again, without getting into a lot of detail of the data in the slide, this really is a tribute to the excellent job that health care providers serving the Alaskan Native and American Indian population have done in providing age appropriate immunization and with very little evidence of disparities in coverage. There are a couple of the vaccines where the sample size, where coverage was lower and so the sample size wasn't high enough to get an estimate. But for the ones where we have estimates there's coverage as high or higher as it is for other groups in the U.S. So again, this really is attributed to the providers who are doing an excellent job of providing immunization to these populations. This is a similar slide that shows the vaccine coverage by race ethnicity for 13 to 19 year olds. We have a number of vaccines that are now recommended for this age group and again, using the same colors, we can see that again, there's no evidence that coverage is not as high for the American Indian/Alaskan Native population than it is for other groups in the U.S. So again, a real tribute to the good work that's being done by the different health systems that serve this population. That said, although there's a lot of good news about VFC, there continue to be many challenges that come with the program. It is important in order for entitled children to have access to vaccines through

the VFC program that they have access to a VFC participating provider. And this is a, this requires constant effort to, as practices close, as new providers enter practice to maintain and increase enrollment of providers so that eligible children do have access to the entitlement that Congress has given them under the law. It's also a little bit of a challenge to reach teens that are entitled to VFC vaccine because they don't go to doctors as frequently, they may go to different doctors than they went to when they were younger. There have been issues in the past with the VFC administration fee. I think under the 1913, or the 2013, 2014 bump up in the Medicaid fees. There's been some improvement, but this continues to be a challenge for some providers. And there's always issues around accountability for vaccine at the provider level. This is a responsibility we take really seriously at CDC that this is a very precious program. And the vaccine that's provided to providers has a very high dollar value. It's a complex biological product which has to be appropriately stored and handled. It needs to be appropriately administered and it needs to be given to eligible children. And so this is something that public health authorities work with us to really try to reassure participating providers. So this is the last slide I was going to show. The VFC program is a critically important program for the health of U.S. children and because of the way the program was based on ACIP recommendations, we've got a strong evidence basis by medical and public health experts for what vaccines are included in the VFC program. The VFC program provides a limited amount of programmatic support for the program and because of its nature as a public private partnership, there's a need for us to work with public health as well as other entities to make sure that eligible children are able to receive the vaccines that they're entitled to and be protected from vaccine preventable diseases. Before we take questions, I want to introduce one person who is here in the audience who is Brock Lamont, over there, who is the chief of the Program Operations Branch in Immunization Services Division that actually, where our cooperative agreement with, the state public health agencies resides. And he may, it's possible he can answer some questions if I can't. So I wanted to point him out. So that was everything I had prepared and I would be happy to answer questions if there are any.

Councilman Chester Antone: Jay?

Dr. Jay Butler: Thank you, Mr. Chairman. And thank you for the presentations. I'm actually going to go to the first presentation rather than the VFC presentation. We appreciate the orientation to the role of Congress in defining the lines in the CDC budget that have been provided for us during the past two days. And as I look at the grants that you've listed out here, and thank you for providing that background also, I am impressed that the impact of the zeroing out of the NPHII grants as well as the CTG grants, is large in Indian Country. We're all eagerly waiting as are you, to hear more about the community prevention grants. But I also noticed there was, at least on the materials that were distributed through NACCHO and new funds that were marked as block grants. And if that's correct, I guess the question I would want to raise is where

will Indian Country fit into that? Oftentimes when we look at block grants, at least many of us think that's money that goes to states. And I just, I guess the bottom line is I want to make sure that CDC is aware that money that goes to states doesn't necessarily reach Indian Country. Oftentimes, doesn't reach tribal nations. Thank you.

Sallie Morse: Noted, thank you.

Councilman Chester Antone: Lisa?

Lisa Pivec: Yes, Lisa Pivec, Oklahoma authorized representative. My question would be, it's not really a question. It's more a suggestion. As I looked through the grants in the listing. I think it would be helpful from our perspective to know the difference between grants awarded directly to federally recognized tribes and those awarded to native organizations.

Sallie Morse: Okay. We can work on providing that additional information for you. Thank you.

Councilman Antone: I just have one question and that is what percent of that \$223.7 million goes to VFC for AI/AN?

Sallie Morse: That information, I believe is on the pie chart. So VFC funding is \$163.8 million of total AIAN program funding, and it's 73 percent.

Councilman Antone: The other percent is in grants and contracts.

Sallie Morse: Right. The other is contract funding is 14 percent of the grand total and grant funding is 13 percent of the grand total.

Councilman Antone: Okay. I think, at least since long ago, that was what we wanted to know, to distinguish that from actual grants and contracts, because then that gives us an idea of how much fund actual funding direct to tribes is versus the VFC. I think over the many years, we've asked about that. We were never really given any numbers, but now we know how much is VFC and how much actually goes to tribes, because VFC is kind of like what, inter mural or what's that term? Something of, well they had internal, external and inter mural at that time. That's how the budget was explained and since that time, we have been asking exactly that distinction that you just made because now that gives us a better idea of 26 percent going to AI/AN because this other one is the entitlement.

Melinda Wharton: Right, three-quarters of it almost.

Councilman Antone: Thank you. And Ms. Kirsten Pope.

Kristen Pope: I'm here to assist Melinda in case you had any additional budget formulation questions.

Councilman Antone: Herman Honanie?

Chairman Herman Honanie: I just have two very important questions. The first question is, and I'm embarrassed to ask, but what does VFC stand for?

Melinda Wharton: It's Vaccines For Children program.

Chairman Honanie: Okay. I kind of thought that.

Melinda Wharton: I'm sorry. I should have made that, I totally should have made that clear. I'm sorry I didn't.

Chairman Honanie: And then the other question is we've been talking here for the last day and a half or two days, and it didn't really occur to me until now to ask this question. And that is that do urban Indian Health centers receive funding from you all as well?

Melinda Wharton: Any health facility that participates in the VFC program receives VFC vaccine for eligible children. The small amount of operations funding goes to our cooperative agreement holders, which are state health departments or a small number of urban health departments. And that generally provides the staff that do the enrollment and the quality assurance and so forth. But it's a relatively small amount of money.

Councilman Antone: Mr. Rex Lee Jim.

Vice President Rex Lee Jim: Thank you, Mr. Chair. I have a question regarding funding that goes to the states. Do you have a tracking system of how much of that actually filters down to the tribes and beneficiaries?

Melinda Wharton: I think the answer to that is no. This largely supports staff that end up working with all the 45,000 VFC providers to do quality assurance and education within those provider offices. So presumably, all the children who are eligible within the VFC program benefit. But it's not possible to allocate that funding to a particular population because it basically supports the staff that do those activities that I identified on the slide. Brock, do you want to add anything to that?

Brock Lamont: We collect different information sources as well as how the funding is being used and we set overall guidance in our immunization program operations

manual that pertains both to the 317 and the VFC funding. And we do site visits to our project officers and work to assure that the immunization, the IPOM as we call it, the Immunization Program Operations Manual, standards are being met. We do track information also from a budgetary standpoint in a system that we have. But as Dr. Wharton said, it's very difficult for us, particularly with VFC when you're talking a very limited amount of funding that's not supporting VFC to be able to track it back directly to a specific population, like in this case, American Indians or Alaskan Natives.

Vice President Rex Lee Jim: I was not just asking about the vaccine program. I'm asking about all of the grants. When you talking about ones that goes to states.

Sallie Morse: I would have to go back through the entire list of grants with more detail to see what additional information we could tease out between what's going to states versus what's going directly to AI/AN. So we will work on providing that information but I don't have it available right now. Do you want to? This is Michael Franklin. He works in the budget office.

Michael Franklin: Thank you and good afternoon everyone. To be a little bit more specific to that question is that when the funding that is awarded to the contractors, or in this case, even to the grantees, that funding is provided to them. As far as any more additional details regarding who receives as a sub-benefit as far as funding is concerned, we would have to consult PGO for that, our procurement and grant office. But for overall, those fundings are received to the awardee who won the award for that grant or contract.

Vice President Rex Lee Jim: I'm just wondering because the states do use our numbers to ask for that funding, and as part of your responsibility I would like to believe that to ask that since you use Navajo numbers, let's say the state of Arizona, and this is the amount you get based on that numbers, we would like to know how the Navajo people benefit directly from this grant that we're giving.

Michael Franklin: Well, we will look into that. I know that is a question that has been asked before. But we will look into that and see if we can get you more of a finite answer.

Dr. Ursula Bauer: Can I just add another perspective. We, speaking for the Chronic Disease Center, we don't typically fund on a per capita basis when we fund state health departments, although sometimes population is a component. We also don't require that our state health departments depending on the grant address every population or a specific population within the states. So sometimes, that might be a requirement of a grant, but other times, it might not be. So it wouldn't be the case that we could look at our portfolio of grants and say it's \$100 million and \$2 million must go to tribes. That's

not typically the way it works when we fund state health departments. So we wouldn't be -- we wouldn't have that information and we often wouldn't have that expectation. That's why we try to have separate dollars that do go directly to tribes or tribal serving organizations.

Vice President Rex Lee Jim: So the follow up question to that was how do you increase that money that goes to tribes, because we are rural areas, and we are several, a couple of decades behind in a lot of the things that we do, so we need an increase in that area.

Dr. Ursula Bauer: Now that is the multi-billion dollar question. And that is the question I am desperately seeking an answer to as well. One of the things that we do, and that's the big we around this table, CDC and all of our tribal partners, all of your population, is making the case to the funder, so that we can get dedicated lines the way we have dedicated lines in the Vaccines For Children program, so that when I get my budget from Congress, I'm actually told these dollars will go to tribes. That would help me a lot in developing programs that would be of great benefit to all of you. Right now, I can take some of my dollars and dedicate them to tribes, but I have no mandate to do that, and sometimes, I'm not allowed to do that. So we do need to work together to figure out how to grow that pot of dollars for Indian Country.

Michael Franklin: Right. And to add to her comment. Also, this morning, Ms. Pivec, she made a comment that I think was something that we should all look forward to. How we could mentor them, mentor the AI/AN population as to what they can do as far as developing projects, so when funding becomes available, that they would be ready to go and then they would be eligible for these particular projects if we have a statute or directed by Congress by the appropriations. So that's another way. And I thought that was a very well stated message this morning.

Vice President Rex Lee Jim: So I guess I would like to see at the next meeting, is the budget line items in Congress that this amount is for American Indian/Alaskan Native programs and the amount, because we would like to see that and begin to work with Congress and ask for increases in those areas because we as tribal leaders can do that. Go to Congress, lobby them, We are able to provide testimonies and different programs in different areas. And if we know that, and where more money is needed, we can advocate for that and ask our lobbyists to work on it as well. And the other is to be created about, like you said, you're not mandated to do so, but how do you create a mindset and say this is such an important area that I can, wherever I'm allowed I can increase in that area and would like to work on those areas as well.

Michael Franklin: Good point. And as you said, developing your internal staff, developing ideas and projects that will at least be eligible for these particular funding opportunities.

Sallie Morse: If I could add here, the group that I mentioned with whom I had involvement at the National Science Foundation was the American Indian Higher Education Consortium and they were successful in working with Congress because the National Science Foundation does have a dedicated line called the TCUP program which is Tribal Colleges and University Program for STEM education. So that is at least an instance of a case that I know worked out.

Councilman Antone: Thank you and now before we go to the behavioral risk factors round table discussion, I just want to acknowledge what Vice President Jim said. In the past, the federal or the financial management office had tried to, or initiated what they wanted all states receiving CDC funds and having tribal populations as part of their proposals to seek [inaudible] from the tribes that they were getting benefits from those programs. I don't know where that is or if that fizzled out. But I thought that was a pretty good idea because you went to the tribes and you asked them are you getting any services from the state getting awarded certain funds in the past. If so, then we would ask additional information, FMO would ask additional information from the states before they awarded anything. And so that started, and I don't know where it is. I think it's about four years now.

Sallie Morse: I can follow up with that. I have not been made familiar with that activity. Maybe Michael has an update.

Michael Franklin: Yeah. Four years ago, as you know, Chester, when we had other leaders here, at some point in time, they was initiating a sub-budget committee quote unquote that they had took off. But that particular committee, which involved the TCAC members as well as some CDC members specific, that did at one point begin. But at the same, within probably less than a year, that sub-committee didn't grow any more, and so.

Councilman Antone: I might correct you on that. It wasn't the sub-committee. It was the Financial Management Office who initiated that initiative to require states to ask tribes in their area to sign and say yes, we are receiving those benefits from the state. What you're talking about, the sub-committee on TCAC at that time, was called Tribal Consultation Advisory Committee. Was for the financial folks and I believe you were a part of that to help us see if we can dedicate more funds to American Indian/Alaskan Native. We didn't work, we tried to do that. But one of the issues that held us back was the actual VFC percent, which we finally got today, versus the actual amount of funds

going to contracts and grants. So that's, I don't think that's a true statement, because if the initiation of that process was in FMO and they said this is what we're going to do.

Michael Franklin: Okay. Well, we'll look into that.

Councilman Antone: Thank you.

Councilman Antone: Mr. Gilbert?

Mr. Tim Gilbert: Thank you, Mr. Chair. I kind of feel like a latecomer to this, but I guess I'm, it's been a reoccurring theme that we've talked about how monies come to tribes or not. And I don't know if somebody feels comfortable enough on the CDC side to kind of articulate what some approaches might be to get a little further along on that conversation by the next meeting, because it feels like we have stated around the table pretty uniformly what are some possible next steps to get a handle on that. That said, in my own mind, I have a, I'm thinking of our tribe's relationship with the state of Oregon. And it's not all on CDC end to fix this issue. We have regular meetings, you know, state and tribal consultation meetings and it's my understanding that those relations vary a lot from state to state and some tribes have good relationships and some tribes don't. And it's part of my role to work that end of it, because there's some responsibility yet at home at the state level to talk with them and ensure we're going, that we're playing with each other fairly in terms of going after the same pot of money. That said, can I just – I have just two really quick questions, to jump over to the previous topic. But VFC, I can't, we were talking amongst ourselves here. Did you show us a slide where you actually showed actually number of recipients of vaccines by either IHS area, or by state is one question and the second one is Medicaid expansion going to throw off your projections for what you're going to need?

Melinda Wharton: I did not show a figure that showed the number of VFC eligible children by state, for example. I think we've probably, I mean we have those estimates, but I didn't show them. The estimates are that, in terms of thinking about the impact of the Affordable Care Act on the VFC program the estimates were that there would be a small increase based on the assumption there would be a modest increase in Medicaid. Now I don't know how much of that was contingent upon the Medicaid that not all of the states initiated or not. But we don't expect the VFC program to get smaller, or not much, because so much of the new insurance in this population is likely to be Medicaid. Do you want to add anything to that?

Kristen Pope: So the estimates for increase were among the adolescent populations that would now be eligible at the higher rate of federal poverty level. The decrease would be among the pediatric population that would be moving into state exchanges out of Medicaid. And so it does tend to wash out any kind of real change within the

program. So we're not expecting any major changes. However, there are expectations of modest increases over time.

Councilman Antone: Okay. Well, thank y'all very much. Very good discussion and we'll work on that Mr. Franklin, and hopefully we'll get somewhere. And I'm going to go ahead and call up the behavioral risk factors round table. Presenters.

Councilman Antone: I'm just going to leave it to my order of presentation is Jo Valentine, and we'll go ahead and go in that order then. I recognize Ms. Valentine.

Jo Valentine: Am I on? Okay. First of all, I just wanted to say what an honor and a privilege it is really to have this opportunity to talk to you about the issue of STDs in Indian Country and I really again want to commend the efforts of this council and what you're trying to do and I look forward to many opportunities that we'll be able to work together on this particular challenge. I also want to acknowledge in the room that my division director has made it back over in the afternoon. Dr. Gail Bolan, so just to sort of really illustrate our commitment at the division level to working with enhancing the sexual health of our American Indian Alaskan Native citizens. And I also want to acknowledge a member of my team, Mr. Scott Tulloch who is also in the audience. And many of you may know him. He has had a long history of working in Indian Country and we're really excited that he has joined us at the division level to help really move this particular project forward. I don't have to tell you that the issue of sexually transmitted diseases in the United States is a very big problem. In fact, chlamydia infection is one of the most frequently reported infectious diseases in the U.S. Gonorrhea affects different racial and ethnic groups disproportionately and then of course, we have the issue of untreated syphilis and its adverse outcomes of pregnancy related to, particularly to maternal and child health when it comes to primary and secondary syphilis. One of the issues that's been long standing is that we've had elevated rates among American Indian Alaskan Native population. Chlamydia among American Indian/Alaskan Native is the second highest. And gonorrhea as well in the U.S., the third highest rate of primary and secondary syphilis is also in this population. And we've begun to see, unfortunately, increases in gonorrhea in Indian Country. Much of it has been related to what's been happening in some of the areas around the oil exploration or sort of the new sort of outbreaks of issues in the Dakotas where folks are coming in and we're seeing an increase rate of problem in those populations. Unfortunately, as the problem gets worse, we still also face the issue of having limited resources, particularly the Indian Health Service is chronically under funded when it relates to STD control. And we realize also that our efforts to really reach folks in urban Indian populations, particularly in states like California and New York have really left much to be desired. So we are really trying to step up that effort and improve those outcomes. But of course, we are facing a situation where we have competing health care priorities. In my office in particular, we deal with the disparities of STDs in the country. And you might know there

are different levels of disparities across the country in different populations. And so we have a limited budget but we are trying to spread those resources and get the most effective outcomes for our citizens. Again, one of the things important for American Indian/Alaskan Native people is the variability of STD prevention services that are available to them. This slide just sort of highlights what some of those issues are, particularly in IHS tribal and urban Indian health care organizations, and that there's a wide range of screening capacity in these particular facilities and unfortunately there's a great deal of turnover in these facilities as well. And the graphic there just depicts some of the challenges that the IHS finds in terms of staffing up their health care delivery system. So in light of all of these different challenges and the kind of work we're trying to do is we really find that it's important for us to partner with folks who are working effectively with the population. And so one of our main partners in the past has been the Indian Health Service and that continues to be true. But we're also expanding our efforts to work more directly with tribes and also with non-government organizations that are working directly for the benefit of American Indian/Alaskan Native groups, like the National Center for AIDS Prevention, as well as the now new partner, the Association of American Indian Physicians. And both those particular NGOs are working on health education, not only of just community members but also of professional staff in facilities to make sure that we're building capacity in Indian Country to do STD prevention. And some of those outcomes have included improved surveillance activities. So we're better able to find cases. And once we can find cases, in many instances, we're able to actually treat them and interrupt transmission. We've also improved the protocols in some of the health care facilities to be sure that folks are really again screening and looking for folks who might need to get these services. We make sure that we provide technical assistance not only to state and local health departments, but also to Native American organizations, as well as making sure that we're working very closely now with the tribal epicenters as new partners. We're pretty excited about the work we've done with our electronic health records and how we've begun to be able to enhance those efforts to help physicians, particularly in clinical settings to help promote the notion of screening. We've again, like I said, we're very committed to capacity building because we are a small unit. There's only four of us in our unit. But we understand that the way we maximize our ability is to get that technical support out to the people who really do the work. And that's our primary objective. And with that, we are really committed to the notion of quality improvement initiatives. So some of the lessons learned that we've begun to see, again the value of the electronic medical record is really important. Helping clinicians know when, with the flag, to help them know what they should be doing, when they should be doing it. It really has increased the screening capacity for instance with chlamydia to help us actually make sure that the women who need these services are actually getting these services. And we really understand the value of partnership again, because that is what helps to really enhance our efforts. We're especially proud, for instance, that when we've seen outbreaks of infectious disease like syphilis for instance, we've been able to get on top of that, and

working very closely with the tribes. In this instance that's depicted here, we were able to actually get that epidemic under control. Again, quality improvement initiatives really are important and that's part of the capacity building. And again, you can see here the outcomes of our efforts to really get quality screening in place. You can see it's gone from, screening for HIV once in a lifetime now has increased from 8 to 381 percent. Screening for HIV in the past year increased from 47 to 270 percent. And screening for chlamydia improved between 9 percent and 467 percent just by making sure we put these quality initiatives in place and working again at the field level to help folks build their capacity. And another example here we want to highlight is the work we've done directly in the Navajo area where they were able to actually adopt the protocols and procedures and actually put those into place. And again, now they're operating independently and doing the kind of work that needs to get done. So what are our next steps? Most important is to continue those partnerships and keep expanding those partnerships. And opportunities like this, having a chance to talk with you is a way that we can help to really build that. We want to also make sure that we disseminate our promising practices and lessons learned that we can share those with you. And if you will refer to your binder, you will see a number of examples that we included there as resources that you can find out more information about and have more tools available to you. We also are very committed to making sure that our state and local health department partners are having increased capacity to work more effectively with tribes. In fact, we're very excited about our new program announcement that just came out, which actually has specific language that requires the states to really work more proactively with the tribes. And we borrowed that language from a letter from director Kathleen, so secretary Kathleen Sebelius, when she directed the governors to work more specifically with the tribes in making sure that resources actually get to the people who need them. So we're very excited about that. And we are monitoring that very closely. And of course, we want to really work more directly with IHS and expand our partnership with them to really address STD control and specifically. So I just want to say again what a great opportunity and how much we really appreciate it. What you'll see here is in your slides, you'll see my name as well as Scott's, to say yes, please call us directly. Any time you have any questions. You'll also see that listed in your resource guide as well because we really believe in the power of conversation. So don't hesitate to pick up the phone and call us or send us an e-mail if you have questions or you need help. I always say as a social worker, if I don't know the answer, I know who to go ask. And so I will find that answer out for you. But the main thing is we realize that this work really needs to be done. We have serious concerns about what's going on in terms of the outbreaks that we are seeing that are happening in certain parts of the country. And we know that we can do something about that if we're working together as a team, so thank you.

Councilman Antone: Thank you and then we'll go to Donna McCree.

Dr. Donna Hubbard-McCree: Good afternoon and I also want to echo what Jo just said about how honored I am to have this opportunity to speak with you. I'm Dr. Donna Hubbard-McCree. I'm the Associate Director for Health Equity in the Division of HIV/AIDS Prevention. And I also am happy to say that my presentation, as I was directed, will focus on mother to child transmission of HIV. And we have our subject matter expert in the room as well, Dr. Steve Nesheim who really is a subject matter expert for the division around mother to child transmission. I also wanted to say that we included in your packet, information on the epidemiology of HIV so that we wouldn't have to spend a lot of time talking about that, as well as some of the background work around our efforts in preventing mother to child transmission. What I'd like to do is, for this ten minutes that we have, and again, my focus is on mother to child transmission. I think that's complementary to the remaining panelists. Give you just a brief overview of the epidemiology of HIV as it relates to mother to child transmission. To talk about our framework for prevention and again, Dr. Nesheim is the expert on that. I have a closing statement and I guess we'll be taking questions at the end of the panel. So here, first I'll direct you to the sheet that you should have in your packet. Really, that does a great overview of HIV among American Indian/Alaskan Natives. You see the fast facts at the top. And the numbers really speak to themselves in terms of what we see with new infections as well as diagnosis. So I'm just going to say something a little bit about our case surveillance around diagnosis when it comes to perinatal infections. The estimated number of HIV diagnoses since 2011, and that's the most current data we have. This is in the United States independent areas and this is diagnosis, regardless of stage of infection, not new infection. There were 49,273 cases, males greater than 13 years diagnoses you see about 39,000--38,825. Females greater than 13 at diagnosis about 10,257. Children less than 13 at diagnoses, 193. Perinatal infections, 128 and according to the surveillance data, they were non-reported among the AI/AN populations. We looked at estimated numbers of persons living with HIV. That's at the end of 2010, the most current data. And there were a total of 872,990 people estimated to be living with HIV. More male, 653,126 male. You see the numbers for female. For AI/AN females, and we included that number because that represents the number that we would be looking at for perinatal infection, 836 and for AI/AN children less than 13 years at year end, the number was 7. Okay, so the next couple of slides are sort of a pictorial representation of what you already have in the fact sheet. This looks at our diagnosis of infection. Again, these are 2008 to 2011 data. And you see the disparities there in rates of diagnoses. You see the line, sort of blue teal looking line at the bottom represents American Indian/Alaskan Native populations. This slide is a pie chart representation again. This is looking in children that are less than 13 years. We have it by race, ethnicity. The pie chart that's on my left actually looks at the number of diagnoses. The pie chart that's on my right gives you a comparison by the size of the population in the United States for that particular year. And if you look down at the bottom in terms of the colors, sort of the teal blue again represents American Indian/Alaskan Native from the surveillance data. And you see the charts there. This slide again looks at diagnosis

among children less than 13 years. This is age of diagnosis, again trend data. Looking at United States in the six dependent areas, and you see the line in the middle there sort of delineates months. So you're talking really about perinatal transmission looking at. And then those that are in terms of age and years. And this pictorial is really around persons living with a perinatally acquired HIV infection at the end of 2010. So you can see the states in the darker bars down at the bottom, sort of the magenta, where you see greater than the 300. And this is AIDS. So we're talking stage three AIDS classification among children age, less than 13 years, again by race, ethnicity. This is looking actually at a nice slide from 1985 to 2011. This is in the United States in the six dependent areas. And you see the slide again, sort of the teal color again, representing American Indian/Alaskan Native populations. So given these data, what we recognize is there are some HIV surveillance challenges because not everyone is aware of their status. Data that were published in 2012 tell us that about 25 percent of AIAN populations with HIV do not know their status. And that's an issue because if you're not aware of your status, you can't be linked to care and treatment. Not everyone that's tested actually reported. So that's an issue. And one that we're really working with, is that not all of those reported are correctly identified by race ethnicity classification. And in recognition of that, and I included this slide. We were directed by the national HIV strategy for the United States to report on how we would improve HIV surveillance among American Indian/Alaskan Native in the United States. I did bring a copy of that report with me. It is available also on our website. And it was written to address that last challenge that we walked about in terms of being able to adequately identify populations by race ethnicity. And the report was actually developed with a literature review, focus groups, key informant interviews. There were several action steps that were involved. And there were five standard practices that we recommended be implemented. That was first to look at a protocol for routine opt out HIV testing in accordance with our current guidelines. We also recommended that providers who serve AI/AN patients, including social service providers, CBOs, laboratories follow up making sure that we get a reporting of all of our positive HIV tests to state and local health departments. We also thought that present in our surveillance report we should present cases with documented single AI/AN and race. That is AI/AN only without Hispanic ethnicity and also separate out those. Present AI/AN cases with and without Hispanic ethnicity. Also to analyze and present our summary information annually and to separate it out from all other race ethnicities if the numbers of cases are sufficiently large enough for us to do so. And to send the surveillance reports and our summary information directly to tribes, agencies and organizations that have expressed a need for this information. It's a great report and again, all of the recommendations are available on our website. So now, getting back to our framework for prevention around how do we work to prevent mother to child transmission and this is a nice slide. I won't go over everything, but you see sort of on my left, we talk about some of the opportunities that are missed, and at each stage of those missed opportunities we provide a prevention option. And just looking at a couple of those at the top, making sure that primary HIV prevention is provided for

women and girls. And we also look at adequate prenatal care, preconception care, providing ARV prophylaxis to everyone that's eligible. And that pictorial is also available in your packet. And this comes from our website. We have a detailed framework to eliminate mother to child transmission of HIV. Sort of uses the same concepts that were presented in the previous slide, but shows it sort of in this graphic so you see how everything works together so we have this kind of comprehensive real time case finding. And Dr. Nesheim can give you background on that if you're interested. Also in your packet, you should have a sheet that describes this graphic in detail. And our recommendations around it. And so lastly, our goal then is of course, the vision of the national strategy which is that the United States will become a place where new HIV infections are rare and when they do occur, everyone, regardless of their age, gender, race, ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have unfettered access to high quality life extending care free from stigma and discrimination. And I would like to thank Dr. Steve Nesheim, Mr. Andrew Mitch and Dr. Suzanne Whitmore who are really our experts around surveillance in mother to child transmission for their input in the development of this presentation. And I am happy to answer your questions at the end. Thank you.

Councilman Antone: Howard Goldberg.

Danielle Arellano: Hello. I am Danielle Arellano. I'm a public health analyst with DB Consulting Group with the maternal and child health epidemiology program in the division of reproductive health. And with me is Dr. Howard Goldberg who is acting tribal liaison of the division. We were invited here to present information on fetal alcohol spectrum disorder, or FASD. And although we don't have expertise in FASD in our division, we do have other related information to share that we hope you find useful, if not in today's conversation, then going forward into the future. And I'll cover this in the next graphic. So the mission of the Division of Reproductive Health or DRH is to promote optimal and equitable health in women and infants through surveillance, research, leadership and partnerships in order to move science to practice. The priority areas of our division include pregnancy health and care, infant health, newborn health and fetal health as well as women's reproductive health from menarche through menopause. We do not oversee grants or administer funds to tribal programs in our division or programs directly pertaining to FASD. One of the core functions of our division is surveillance. PRAMS, or the Pregnancy Risk Assessment Monitoring System is a population based surveillance system that describes and monitors maternal experiences, attitudes and behaviors before, during and shortly after pregnancy. And this surveillance system was designed to supplement vital records data. And currently, 40 states and New York City currently participate, representing nearly 78 percent of all U.S. live births. So PRAMS is important because it's the only multi state population based maternal and infant health surveillance system that obtains data representing American Indian/Alaskan Native mothers. And with that being said, there is room for

improvement. American Indian mothers have had consistently lower response rates to the survey compared with other groups. And a study published in 2008 examined how response rates could be improved. Although contact rates among American Indian mothers were lower in comparison, the study found that once contacted, most mothers, regardless of race, did complete a survey. So the study concluded that in order to increase participation among native mothers, adaptations in methodology may be necessary to increase engagement and participation. So South Dakota tribal PRAMS was the first tribally led and focused PRAMS in 2007. It was a point in time survey that was born from the need for high quality generalizable and detailed maternal and child health information specific to American Indians in South Dakota. The Yankton Sioux Tribe was the grant's recipient and project leader. They partnered with the area tribal epidemiology center, the state departments of health and the Tribal Chairmen's Health Board including the other eight tribes in the state. 1,300 surveys were delivered to women in the area via mail and mothers were able to respond by phone via standard PRAMS methodology. But the survey administrators also partnered with tribal WIC offices and made hand delivery and pick up available to reservation residents. And the project was very successful in achieving a nearly 73 percent response rate. Since the South Dakota tribal PRAMS project, it still exists as a model and an inspiration to continue efforts to increase native response rates with supplemental funding from 2011 to 2013, several PRAMS states were able to enhance their outreach to native mothers to increase participation and strengthen state PRAMS project collaboration with tribes. New Mexico, Oregon and Washington were the grantees. And during this time, Alaska, Michigan and Wyoming also enhanced their PRAMS outreach to tribal communities, although they did not receive additional CDC funding. So strides were made in relationship building among the three funded states, and actually Oregon State hired a permanent tribal liaison focused on maternal and child health issues. But it is yet to be seen if response rates have been affected. The 2011 through 2013 data have not been released yet and once it is, we'll be able to compare it to 2010 as a baseline. So there are many maternal and child health and preconception health indicators that are available through the PRAMS survey in addition to maternal alcohol and tobacco consumption, and provide counseling about adverse effects of alcohol, the survey asks about attitudes and feelings about the most recent pregnancy, prenatal care, physical abuse, pregnancy related morbidity and including conditions such as hypertension and diabetes. The survey also asks about infant health care, contraceptive use and family planning. And there are mental health questions as well as emotional and social support. So these are the questions on the survey that gauge alcohol use in the three months before pregnancy and during last three months pregnancy. And the questions include how many alcoholic drinks did you have in an average week and how many times did you drink four alcoholic drinks or more in one sitting. And this is how PRAMS defines binge drinking where one sitting is a two hour time period. The survey also asks if a health care provider discussed the effects of drinking alcohol during pregnancy at a prenatal care visit. So we just have a little bit of data to share with you today. And this

table shows data for the questions that we saw in the previous slide. And it shows the prevalence of women reporting alcohol use and provider counseling about alcohol use comparing American Indian/Alaskan Native mothers and non-Hispanic white mothers in the eight PRAMS states where the Native population is five percent or greater. So from the table, we see that more non-Hispanic white mothers reported consuming any alcohol in the three months before pregnancy and during the last three months of pregnancy than American Native mothers or Alaskan Native mothers and we also see that more Native mothers reported any binge drinking compared to non-Hispanic white mothers during this time. And that last variable on the table shows a greater percentage of Native women reported that a provider spoke with them about alcohol use during pregnancy at a prenatal care visit. And this is just one example of what PRAMS data can show. But the survey does offer the opportunity to explore various indicators associated with alcohol use to see what other factors could be affecting women's lives and their behavior in addition to informing programs and interventions. So to move away from CDC work for a moment, I thought it was important to highlight one example of really great prevention work going on in a tribal community. Sacred Beginnings is a preconception health education program that was initiated by the Oglala Sioux Tribe in South Dakota. It began in 2011 and this is not a CDC funded project. This work emphasizes the importance of women's health prior to conceiving a baby in order to prevent disorders like FASD. The program is primarily an education intervention, targeting middle school age girls. And the curriculum that they use was developed by a tribal working group at the tribal level. And they've incorporated cultural elements into all of those topics that you see listed on the slide. In addition to the education intervention, there's also a community outreach component and a professional development component. There was an evaluation paper that was published documenting their initial successes of the program and that resource link is available at the end of the presentation. And we've also included a write-up as a hand out for you in your binder, so that if you are interested in learning more about how the program was inspired, where they got funding and how they achieved their successes, that's available for you. So we have focused a lot of the presentation today on PRAMS because it can be a useful tool. But we are excited to be here today to let you know that DRH offers technical assistance through the maternal and child health epidemiology program. We provide services and resources and program evaluation planning as well as data analyses. And most recently, we worked with the Northern Plains tribal epidemiology center to analyze data from their South Dakota tribal PRAMS survey. They produced a statewide surveillance report in 2009 and their funding lasted for three years through the point in time survey with CDC. And they had made a promise to the tribes to report back, so we were able to provide assistance in analyzing that data to report back to the tribes. We've also worked with the data to produce health issue briefs based on the tribe's needs and the analysis plan that the tribal working group had established back when the program started. DRH also responds to maternal and child health related issues that require epistemological investigations. For example, several years ago a

team was sent to a reservation after there was a report of increase in infant deaths. And lastly the maternal and child health epidemiology program also offers direct assistance through supporting CDC assignees in the field to build capacity at Native-serving organizations. Also DRH has a history of providing technical assistance on population based surveys with maternal and child health indicators to more than 30 tribes. DRH has worked with tribes to build survey capacity by developing questionnaires, designing sampling approaches, training interviews and developing data entry programs. So all in all we are here for you to reach out, whether it's to initiate a request about something we've discussed today or another maternal and child health related need that you have. Or if it's even just to get information about reaching the right person in our division. So here, we have included several CDC DRH resource links via the web. The first link there is a web page we published last summer outlining all of the activities in DRH that have to do with American Indian/Alaskan Native reproductive health. And we would love for you to look at that, look at that and give us feedback about what you think the content should look like or if there are any changes you think should be made. Also, here we have listed the MCH epi program web page and the Division of Reproductive Health web page. And lastly, there is a resource online that you can kind of play with and investigate a little bit, what PRAMS data is available and checkout frequencies and things like that. So additional resources are the statewide surveillance report from South Dakota tribal PRAMS in addition to the evaluation report that I mentioned that Sacred Beginnings had published. And lastly, there is a maternal and child health journal supplement that focused on MCH practice in tribal communities. And here is our contact information Thank you so much for listening to us and hearing out what, what we have to provide. You're welcome to contact us any time. And you're also welcome to share our contact information as you see fit. So thank you.

Councilman Antone: Thank you. And we'll go ahead and go with Catherine, birth defects and developmental disabilities.

Catherine Hutsell: Good afternoon. My name is Catherine Hutsell, and on behalf of myself and my colleague Megan Reynolds, we'd first off all like to say thank you to Chairman Antone for the opportunity and the invitation to be here this afternoon and share with you about our activities with the CDC fetal alcohol spectrum disorders prevention team, or actually FAS prevention team, pardon me. But we address FASDs as a whole. We've also appreciated the opportunity over these last two days to listen and learn from all of you, so thank you. We are presenting not only work that we as individuals are engaged in, but also I would be remiss without saying that we're also describing work of our colleagues and our partners as well. We're going to share with you our activities around data and surveillance as well as primary and secondary intervention as well as educational and health promotion activities and highlight those activities where we are reaching out to American Indian/Alaskan Native populations in particular. Before I do that though, we're going to be tag teaming back and forth here.

But before I do that, I want to just draw your attention to a couple of things. There should be about four different items in your packet related to our presentation along with the PowerPoint, including a fact sheet. And we'll refer to these throughout our discussion here. But just in terms of the fact sheet to start with, just to make sure we're all on the same page, I just want to highlight a few things because we sometimes find that there are some misconceptions around the topic of fetal alcohol spectrum disorders. And the first thing we always want to say is this is a condition or these are conditions that are absolutely positively 100 percent preventable. And if we think about the challenges that we are faced with in the realm of health, we can't say that about everything. That's not to say that it's easy and that there aren't a lot of factors impacting our ability to do that. But it is 100 percent preventable. These are lifelong conditions. And most people are familiar with and have heard of fetal alcohol syndrome. That is a very clinical term, clinical term, clinical diagnosis. And that's why the name of our team is FAS prevention. But in fact FAS, while one of the most complex conditions on the spectrum, is only one condition of many. And all of them have significant impacts. Again, they're lifelong and affect physical, emotional and other cognitive and cause other impairments and so forth. So with that said, I'm going to turn over to Megan who is going to give us an overview of the data.

Megan Reynolds: Thank you. Again, the data, and actually I'll thank Danielle for giving us an intro already, so I won't go into quite as much detail here. But this slide just highlights some of the publications that our team has done over the last several years looking at drinking in general. We've found that, as you all are probably very aware, surveillance is hard. And finding the numbers for fetal alcohol syndrome and fetal alcohol spectrum disorders and actually knowing who all has it has been difficult. And so one thing that our team is doing has been looking at alcohol use, specifically in women of childbearing age and using that as a proxy for knowing who's at risk. And so sort of you can look at this and you can get more details by looking at the individual reports. But the key trend with this is that the trends are staying the same over time. I think that's what we've been learning is that drinking is not going down, that women who are reproductive age are drinking in large amounts, they're binge drinking and they're continuing to do that when they're pregnant, thus putting their child at risk. And most recently, in January, we presented Vital Signs, which you all heard about this morning, about the wonderful tool that is Vital Signs, coming out. And that was about doctors asking about patients' drinking behavior. And we're learning that doctors really aren't asking. So while we know that it's dangerous, the health professionals aren't screening for it and so they don't know who is at risk and they can't counsel the patients and they can't counsel the women who are then putting their children at risk, or the men who are around the women. So that's just something important that we really have the numbers now to support that. And unfortunately, we have some numbers to look specifically at the American Indian/Alaskan Native populations, but with a lot of our data, it's hard to drill down to those specific numbers just because of sample size. It's the same thing,

issues we have with a lot of our surveillance data. So we don't always have specific numbers, but we know from our work with the populations that it's an issue. Specifically looking at the prevalence of FAS and FASD, our estimates from various different studies is that between .2 and 2.0 cases of FAS per every 1,000 live births. We estimate that FASDs are at least three times as many. So within American Indian/Alaskan Native populations, we believe that the reported prevalence rate is a great deal higher in some tribal communities. Not across the board, we know it's not the same everywhere. But a lot of our studies have shown between 3.0 and 5.2 per 1,000 live births. In your packet you have a spreadsheet that shows all the published studies that we have to reference. You'll see that a lot of them are fairly dated. That's part of the problem that we have with surveillance data and with being able to tell you specific numbers. But again, we've done work with tribal communities and we know it's a problem and it's something we want to address. And we're working to have better surveillance as well to be able to have better numbers. But even without the numbers, we know it's a problem and we know it's something we need to work on.

Catherine Hutsell: Okay. Thank you. So looking at our primary prevention activities related to this, again, Danielle's presentation was a very nice set up for this because you may recall on one of her slides about PRAMS and reported alcohol use before pregnancy recognition as well as after that, in that period of time before pregnancy, many women are using alcohol. And this is all populations of women. And so in recognition of that important opportunity for intervening with women, knowing that more often than not, when a woman recognizes that she is pregnant, if she's been using alcohol, she stops, perhaps unless she has a dependency issue that may require more assistance in stopping. But more often than not, if there isn't a dependency issue, she does stop. But it's that period of time before recognition of pregnancy that where a woman is often at greatest risk. So in collaboration with a number of partners, CDC developed, implemented and evaluated what is now an evidence based intervention called Choices. And you see a picture there, a cover of one of the pieces of our curriculum. And the whole idea is to intervene with women in the preconception period. Those who screen as being at risk for what we call an alcohol-exposed pregnancy or an AEP, because you know we have to have an acronym for everything. But in any event, they are sexually active, but not using contraception or family planning or not using it on every occasion or with every partner. And they're also drinking at what we call risky levels. So we have over the last several years, had translated that work into a number of arena including STD clinics, family planning clinics and community health centers which tie in nicely with our earlier presenters, because we know those are behaviors that are associated with risk. I should also say that part of the intervention in addition to counseling sessions or intervention sessions with the woman, there's also an opportunity for her to have a family planning services visit with a provider. We've also then in recognition of the importance of reaching out to our American Indian/Alaskan Native women collaborated with the Indian Health Service a few years back and

provided funding to them which they in turn provided I might say, I want to say directly to the Oglala Sioux tribe there in South Dakota. And they've been very successful. The intervention has been well received by the women in this community and in fact, their efforts have been so successful that they, earlier this year, received funding from actually, I apologize. It was last year, they received funding from the National Institute of Minority Health to further broaden and expand the reach of their program on the reservation. There's also an effort, a research study still ongoing in Texas looking at the sexual activity, alcohol use, as well as smoking, since we know of course tobacco is a risk factor during pregnancy also. We've expanded our cadre of trainers to expand our reach of the Choices intervention. And this also includes individuals who are native as well as those who have strong experience working in native communities. We also collaborated over the last year with the National Organization on Fetal Alcohol Syndrome, also known as NOFAS, to develop a dissemination plan for this intervention in American Indian/Alaskan Native communities. It included a number of advisors from the American Indian/Alaskan Native population as well as representatives at meetings. And also I want to point out to director Abramson that the National Indian Health Board was also and your Executive Director participated in the meeting also and we were very pleased to have her participation. So we've done that. And if you're also familiar with SAMHSA's National Registry of Evidence Based Practices and Programs, this intervention is now included there. So moving along, another major initiative that we have very closely related to our choices efforts is promoting alcohol screening and brief intervention in primary practices. So we've engaged in a number of activities around data collection. Again, the Vital Signs report that was released last month is one of those components, as well as working with providers through a variety of different projects and, of course, as with all of our activities developing partnerships to advance policy and system level changes. Another activity specific to our American Indian/Alaskan Native populations brings both of these efforts together through the establishment of training and technical assistance centers who are working specifically with primary care clinics who serve a predominately American Indian/Alaskan Native population. They're working with them to provide training and, again, technical assistance on the implementation of both alcohol screening and brief intervention as well as the choices—that's for all populations at the clinic, all adult populations as well as choices for women who are specifically at risk for an alcohol-exposed pregnancy. These activities just got under way last August. In December I went to northern Wisconsin where the University of Wisconsin Department of Family Medicine who is one of the recipients of this award, we worked with their Redcliff community as well as the Fond du Lac Band of Lake Superior Chippewa, and they are engaging in implementation of these activities right now doing all of their readiness activities related to that. Our other award recipient is the Denver Department of Public Health and they're in the process of continuing to engage with a number of different clinics, so if anyone here is interested, they are available to work with. And I'm going to turn it back to Megan to talk a little bit more about some of our secondary intervention activities.

Megan Reynolds: These are just really quick some examples of intervention activities that we have funded in the past to work with children who have been diagnosed with FASD's and just sort of to put up there and you can see more details from our website, more information on those. But just wanted to show that we do have some interventions that we have done. They have not been broadly disseminated yet. They're still writing up results and haven't been published yet, but showing there are interventions that do work with children who have been diagnosed with FASD's. It's not a hopeless case, which I think is great. Sometimes people want to write it off but there are things you can do, once we have that. But more than just structured things, I think the key for all of this is early intervention services. We know there's no cure for FASD's but all the research we've had is that early intervention is what's most important. And even if you don't have a diagnosis because I think that's the struggle with a lot of this is that diagnosis can be difficult to come by and is often delayed. There are guidelines for diagnosis. We have a booklet that's FAS Guidelines for Referral and Treatment that's available on our website to order, but not everybody is comfortable with making the diagnosis. Providers—not every—there's some discrepancies sometimes in that but even without the diagnosis a lot of children still qualify for early intervention treatment services such as speech therapy or occupational therapy. We have a wonderful program here in the National Center on Birth Defects and Developmental Disabilities called Learn the Signs, Act Early that focuses on developmental milestones and on our website we link to just milestones to look for, and this is great for all children regardless of whether or not they're affected by FASD's or just any developmental disability to know what milestones they should be reaching and if they're not, to raise the issue with your provider and seek help. The milestones checklists are in there and they're just a fabulous resource. We also know that Learn the Signs is just starting to have a partnership with Head Start who is going to be partnering with the tribal communities. While they're not specifically focusing on FASD's, they will be working with children who are affected by FASD's and other developmental delays and helping them to grow with that. We also know there are some protective factors that can help reduce the affects of FASD's and these are from, of course, the early diagnosis but then involvement in special education and social services. And a loving stable home environment and absence of violence. So other things we've heard from other people speaking these couple of weeks, other social services that you work with on your tribal communities. So just simple things to make the environment the child is in more stable, the community can help with their development. And there's different types of treatment that are available from medical care, medication, different therapies, training for the parents to know how to work with their child and help them understand what's going on, and more details for each of these therapies are available on our website, which the link is in your packet. Back to you.

Catherine Hutsell: Just to wrap it up real quick here, with regards to a few other activities, we have a network of FASD regional training centers that are university based. They engage in a number of activities. One of them is located in Alaska in Anchorage and they have a curriculum and development guide for medical and allied health professionals that you may find of interest and in fact can obtain more information about a lot of these topics through that document which, again, can be ordered. And then we have a number of partnerships in our team and one of them is with the American Academy of Pediatrics and you see there are a number of different activities but the one I'd like to highlight here is there at the top in that first sub bullet, Pedia, or you just say Pedia Link but I guess there's not another "l" in there, but Peda Link. Basically what this is, is a tool that's been developed through an expert panel that a pediatrician can use in his or her office while meeting with a child to do some preliminary diagnoses, if you will, to determine if perhaps this child should be referred for a further evaluation. So, again, that's a resource that's available for everyone. And then finally, I just wanted to say—actually two things. I mentioned earlier the National Organization on Fetal Alcohol Syndrome or NOFAS and I just would like to highly recommend this organization and their website to you. The website is www.nofas.org. They are a wonderful resource on all aspects of this topic including issues around treatment and diagnosis. They maintain a directory. They try very hard to keep that directory as up to date as possible. But anyway, they're just a wonderful resource for more guidance and direction for prevention, for individuals who are affected by these conditions as well as their families. And finally, obviously, Megan and I and our colleagues are certainly always happy to take any questions or concerns that you may have. Thank you.

Councilman Antone: Are there any questions for the panel? I have a question. You mentioned there was a reluctance to—or maybe I heard you wrong, but there is a reluctance to make a medical diagnosis. Can you expand on that further?

Catherine Hutsell: I don't know that it's a reluctance so much—it's not really a reluctance so much as, you know, when we look at—it require a team, a multidisciplinary team and so including ideally a member of that team would be a developmental pediatrician and you would think there would be a lot of developmental pediatricians in this country, and in fact as Dr. Monroe seems to be aware also, there are not. In fact, you would think that perhaps here in the Atlanta area we would be rich with developmental pediatricians. In the entire state of Georgia we have exactly four. So that's one of the big challenges. For example, here in the Atlanta community one day a week at the Marcus Center, or now actually I think technically they're at Emory, they have just one day a week in which they conduct—they have one diagnostic clinic a week and that may not even be that frequent now. It's just having the resources. So the Pedia Link is one of the answers to the resource shortage.

Councilman Antone: The specific medical part that you listed on there including medications, and there were three others you listed on there, are those the only forms of treatment, those five that you listed?

Catherine Hutsell: Yeah. I mean treatment can encompass a variety of activities and resources. Certainly, when we talk about early intervention is a form of treatment, you know, such as behavior and educational therapy, training for the parents. There are some alternative approaches. Again, there is more information in our regional training center curriculum guide about this topic and in fact, I've got some of the CD-Roms here if you'd like, I'm happy to leave with folks.

Councilman Antone: So might we say then, as you've indicated, that early intervention is the key for either HIV AIDS, STD or everything that we're discussing here?

Catherine Hutsell: I think we would all agree that early intervention, primary prevention—you know, prevent it before it happens and then if it does, then intervene. Right?

Megan Reynolds: Yes.

Councilman Antone: How about those currently affected? That would go back to the diagnosis question that we're talking about right now.

Catherine Hutsell: With regards to Fetal Alcohol Spectrum Disorders, absolutely receiving a diagnosis is very, very helpful. Again, it's challenging. Not because no one doesn't want to do a diagnosis, it's just very challenging to get all the resources together. But any and all times that a diagnosis can be obtained, it's very, very helpful.

Councilman Antone: When you talk about resources as being a challenge, what do we mean by resources?

Catherine Hutsell: Individuals who are trained to make the diagnosis.

Councilman Antone: But we're not talking about services for the individual.

Catherine Hutsell: And availability of services is also a challenge, yes.

Councilman Antone: And the reimbursements of those services would also be a challenge I would assume because you don't have a medical diagnosis.

Catherine Hutsell: Right.

Councilman Antone: Because I had brought this to the attention of CDC, CMS, SAMHSA, IHS, Office of Minority Health. At that time the response was—the only response we really got was from the Office of Minority Health and we did that on a call, two calls, and eventually found out some of the billing codes information. There has only been one person from Alaska who texted and asked about it, so I sent them that link and he indicated that he didn't know about certain codes. He's a practitioner and so now he said I'm thankful that I got this information because I was unaware of these other codes. And I assume that those are what you bill for when you provide services.

Catherine Hutsell: Right, yes.

Councilman Antone: And I also understand that part of that diagnosis is not necessarily for medication or medical treatment, that it's kind of difficult because you have emotional problems associated with FASD. There's a lot of—I saw a list on there somewhere on the computer where they indicate all these things that might affect a child or an adult, and there's a whole lot of them. So I'm wondering if all of those are addressed in the five treatments or are there some that would fall into a different category and is that why they have that team to look at medical, emotional, behavioral?

Catherine Hutsell: Yes. I think that's why it's ideal to have a team approach because one person can't be an expert on all the different domains that are impacted by Fetal Alcohol Exposure. The other thing, too, is the treatment, whatever that treatment is, if it's a pill or physical therapy, occupational therapy, whatever it is, behavioral therapy, it has to be tailored specifically for that individual. So it's a separate prescription for each person.

Councilman Antone: The other thing, when we do a child find on the reservation, we have the specialist that assesses children and that was part of the original question because we are having—I don't know if you looked at our numbers or if you have access to our numbers and I don't have them with me, but we have quite a lot and I don't know if we're one of the tribes that fall into that category where you say some have these and some don't. It's population specific. So that's how we started to find out how difficult it was for those currently diagnosed to go through the educational system and that's why it becomes important because you have this population and we hope it's small, maybe just kind of thinking out loud and it's really big but the actual numbers, maybe they're smaller. But those individuals are going to have a difficult time going through the educational system so for us it became important to find out even just to find out what's out there and how we, if we assess a child as having certain disabilities, then we look for some sort of service that can help address it in order to help this child or person advance through the education system because in the end, as I remarked earlier, they are productive people but they learn in a different way. So we want to make sure—our dream is to make sure that we get back to that point.

Catherine Hutsell: I'm glad you said that because that's one of the messages with the four interventions we have that have been the interventions, their educational and social skills as well as parent/child interaction based, and those have been developed and written up and there's information about those posted on our website. We've got some other studies that are still ongoing and that data hasn't been released yet but the very message of those interventions is that there is hope, as Megan said, and that children can learn and they can develop social skills and so forth and be productive members of society. I'd be happy, with that in mind, to put you in contact with Dr. Jacqueline Bertram, our colleague who oversees the intervening with children component of our efforts and is very well versed in all of these issues.

Councilman Antone: Okay and just to make a few more comments, we also tend to see a lot of those juveniles in detention because of behavioral problems associated with that, and a lot of times parents really scold them day in and day out not really realizing what the problem is. And the society tends to keep them down here because, again, we don't really know, and some may have that problem and it's important that we know at least what that problem is because then it will help us try to figure how best to give the young adults or children something that will help them out rather than spend a week or so in jail, or maybe 24 hours is usually the case but then we have juveniles that are much older that actually go to school in there because they're in there for long periods of time over and over. So I wanted to just say that much because that's why I put that on there, the different areas. I guess, VD, I know that you probably know that at one time we had declared an epidemic of STD's on our reservation but since that time it has went back to a normal occurrence. So we've undid that resolution but we appreciate the help that CDC gave us on that, and we hope that they would give us the same assistance and help on our RMSF issue. So if there aren't any more...Mr. Jim?

Vice President Rex Lee Jim: Thank you. Now that we're going past five we want to roll up our sleeves and start asking questions. Navajo Nation would like to make a statement on PRAMS and I want to allow Ms. Antone- Nez to do that.

Ms. Ramona Antone-Nez: Thank you for your presentations. I just want to share two comments. One is specifically for PRAMS. The Navajo Nation is interested in establishing a Navajo Nation PRAMS which we are now working with the state of Arizona and New Mexico—no, New Mexico and Utah who do have PRAMS and we do understand that Arizona does not. And the majority of our land base is in Arizona, therefore, we're missing a big portion of our population. I just want to have you be informed that we are interested in that. Secondly, this is for our interest in your report concerning the improving HIV surveillance among American Indian/Alaskan Natives July 2013. I look forward to accessing that report because through the Navajo Epidemiology Center we are aiming to establish a surveillance on Navajo specifically for

HIV/AIDS education, screening—well, primary, secondary and tertiary care preventions. So thank you very much.

Vice President Rex Lee Jim: Thank you, and then one other question I have is what kind of programs or funding do you have available for the FASD adult population? As just mentioned by Mr. Antone they allow some people going through the jail system and their families understand and so they get yelled at and everything else. So is there any program out there?

Catherine Hutsell: At this time, the only funding that would—we don't have any funding for if we think of the adult population as over age 18, we don't have any funding specifically directed or targeting that age group, at CDC I should say.

Vice President Rex Lee Jim: Are there programs out there that deal with how to help that population?

Catherine Hutsell: Well, we do have two research studies that we were referring to earlier. One at UCLA and one at the University of St. Louis. The target group for those are, we refer to them as, we characterize as youth and young adult. So those are looking at risk factors, those are individuals who have a diagnosis of an FASD. Those are the individuals whom this research is direct target to develop interventions, identify interventions to intervene with them.

Vice President Rex Lee Jim: That adult population is also a vulnerable populations?

Catherine Hutsell: Pardon?

Vice President Rex Lee Jim: It's a vulnerable population, the adults who are suffering from...

Catherine Hutsell: I think the oldest are 18 or 21.

Vice President Rex Lee Jim: Let me finish.

Catherine Hutsell: Okay.

Vice President Rex Lee Jim: There are adults out there who are in their 30's or 40's who are suffering from this disease and some of them are subjected to sexual assaults as well as to other types of abuses, so the question is because of that is there any study out there and because of that study are there any programs to help them overcome certain obstacles like STD's and HIV and drug abuse and so on?

Catherine Hutsell: At CDC with our program we, ourselves, do not have a specific program for the adult population. I can't speak to other agencies but that might be possible because as you've indicated, they are a vulnerable population. That is certainly well known I think and documented. I don't know if perhaps with the STD program and the other programs if you have anything that—prevention activities or intervening.

Jo Valentine: Specifically targeted to folks with this syndrome, no we don't. We would just be working in general screening and outreach activities to reach all the populations.

Catherine Hutsell: One thing that I did just remember is the SAMHSA, the Substance Abuse and Mental Health Services Agency produces a series of documents called TIPS which stands for Treatment Improvement Protocols; people might be familiar with them and they're on a wide variety of topics and they usually have a number for each one. And over the last couple of years one was developed actually that does address this issue and it's guidance for social workers and other service providers in educating them, creating awareness about what FASD's are, how they impact individuals and to make them aware that they may have clients who have an FASD and how they might recognize that and how they might work with them differently. So that document hasn't come out yet though but it will be coming out. So that might be one resource for helping people.

Vice President Rex Lee Jim: The American Indian/Alaskan Native population group is a higher percentage of alcoholism is huge there and so you would think based on that, that the higher population and because of the size of the population would be a contributing factor to the health disparity that's there, so we do need to address that somehow. Thank you.

Councilman Antone: Well, I want to thank the panel for your responses. I just hope that we can look at treatment more rather than enabling as we do in Tohono because it's so rampant, the sexually transmitted diseases that there's another method used for that so I hope we don't get to that. Thank you all and thank you for being here during this presentation. I believe for the TAC—okay, almost forgot Molly. What we've been doing here is in the afternoon and every evening before we leave Molly gives us our wrap up on what we've discussed and then right after Molly's presentation—I guess so used to saying that—then Judith has something she wants to involve the TAC in. So go ahead Molly.

Molly Sauer: Okay, we have a brief one today since we had so much information come up during the testimony and the other presentations. We'll go back through and try and identify the specific highlights and action items from that, and of course, that will be sent out when we send the minutes out to the full TAC a little bit later. But a couple of key

points from today from this afternoon specifically. One thing we'll be doing is providing more information on funding. I know we were able to identify some of the information that's been asked for in the past this time around but we'll be able to get a little bit more specifically items like which budget line items have been designated or restricted by Congress so that we can assist everybody in working on the advocacy component of this. A big emphasis through all the presentations on prevention and then intervention I think specifically from this panel this afternoon. A few things that came up during the testimony. One, again, emphasis on funding direct to tribes, not through any kind of pass-thru through states or other entities as much as possible, and a need for increased technical assistance and other support for workforce and infrastructure development across the board. And we highlighted several of the major health issues, some of which I know we were able to have presentation on and others I'm sure we'll address in the next meeting. Resounding message to continue moving forward and emphasizing meaningful and effective consultation with tribal leaders. That was definitely a resounding message, so we will continue to do so. I just wanted to throw three reminders in from yesterday just so we're keeping fresh in our mind. First, and I know that Dr. Abramson is going to call me out on this. We do need three sites for the next meeting so if anybody is interested in hosting the summer meeting, we have one, so please do send them to us so that we can pull them together, and dates as well. I know summer is a busy time so if there are any dates that definitely will not work, please let us know. A couple of people mentioned they wanted to provide written testimony and had not yet, so please feel free to send that in to us as well and we will group it with all the others that we've received. And finally, we've talked a few times about the engagement plan and how that will have a great impact on the TAC moving forward, so when you do receive that plan, please do provide as many comments as you would like so we can make sure it's a very robust plan moving forward. Thank you.

Councilman Antone: Thank you, Molly. Captain Wilkins has a few housecleaning items he wants to let us know and then after him I will refer to Judith.

CAPT Craig Wilkins: For the TAC members tomorrow, we'll be meeting in room 247 which is right out the door here.....All TAC members, you've been invited to dinner tonight with the health officials and senior leaders and if you're interested, they'll be meeting right out here in the foyer area if you're interested in going to dinner with them. Thank you.

Councilman Antone: Dr. Monroe.

Dr. Judith Monroe: So thank you. I will not be able to join you tomorrow for your meetings because I need to join the health officers for their orientation to do my part of that. So I did want to take this opportunity to thank my CDC colleagues and the experts across CDC that have joined us for the last two days and will continue to join you

tomorrow. And I also want to give thanks to Craig and Bobby for their great work and to all of our staff in the Tribal Support Unit for pulling the meeting together. But I especially want to give thanks to all of you for your valuable time that you've spent with us, for your insights, for your testimony and for all of your questions. One of the things that we will plan to do soon after the TAC will be to convene internally here at CDC, the leaders that have participated and to do a debriefing and to look for those concrete actions and to move forward because we heard some very specific asks from you that I think we can collectively find a way forward and then we'll get back to you. And then I want to give thanks to Chairman Antone for his work. So we do have this evening for each of you—I wanted to present each of you with a Certificate of Participation on behalf of CDC for all of your efforts, for being here, again for your time and really for the extraordinary volunteerism. I know you're volunteering a lot of your time to help us here at CDC to help you, and it is a two-way street, so I do have certificates for each of you that I'll come around and give. Chairman Antone, thank you very much. Dr. Butler.

END.