

**CDC/ATSDR Tribal Advisory Committee Meeting and
12th Biannual Tribal Consultation Session**

02/10/2015

CDC Headquarters
Atlanta, Georgia

February 10, 2015

Opening Blessing

Councilman Chester Antone: Good morning everyone. We're about two minutes over, two minutes late, but this morning, I'm gonna offer prayer for us before we begin.

(Prayer)

Welcome and Introductions

Councilman Chester Antone: As I said before, welcome to the Tribal Advisory Committee for the Centers for Disease Control. We have been here for a number of years. As you can see, it's the, I believe the 11th consultation, bi-annual consultation. So I, myself, I've been here since I think 7-1/2 years now, my first meeting being at Bainbridge Island down on Seattle, off the coast of Seattle. That was the first one. We've since had another one there, but so I started, and I know Jefferson, to my left here, has been on CDC for, I think at the beginning, and then he left me in charge when he left for NCAI, and I've been there ever since. And I know Alicia Reft, Ramona Antone-Nez, and Joe Finkbonner's been around, Cathy, Ms. Quisno there. The newest member we have is Delia Carlyle and in California, Geisler. And who else do we have? But we have these biannual meetings; one here in CDC, one out in Indian Country, which I'll be talking about later on. And I'm gonna go ahead and introduce Judith A. Monroe, the Deputy Director for CDC's Office of State, Tribal, Local, and Territorial Support.

Dr. Judith Monroe: Thank you, Chairman Antone, and let me give a warm welcome to all of our TAC members coming here to CDC. We're really excited to have you and look forward to a really good meeting today. I'd also like to welcome all of my CDC colleagues that are joining us, and to give a welcome to our sister agencies. We have some federal agencies represented today. We have William Elwood from the Food & Drug Administration, we have Reginald Hammond from the Administration for Children & Families, and Stephanie McCladdie from the Substance Abuse & Mental Health Services Administration or SAMHSA. So we're really excited to have you join us. We're also excited to have national organizations joining us today. We have the Association of American Indian Physicians, represented by Delores Welch, and Bridget Canniff is with us today from the Northwest Portland Area Indian Health Board. So I want to welcome them. And then additionally, we have our friends at the National Indian Health Board, and we have quite a representation today, so a special welcome to everyone. Robert Foley is with us today, Jackie Engebretson, Kevin English, Jennifer Giroux, Virginia Hedrick, Kristin Hill, and Laura Sawney-Spencer, as well as Nicholas Barton. So quite a representation. So just welcome to everyone. Joe?

CAPT Joe Maloney: Good morning everyone. My name is Joe Maloney. I'm the Acting Associate Director for the Tribal Support Unit, and on behalf of Dr. Monroe and our Tribal Support Unit

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staff, I'd like to welcome everyone today to our Tribal Advisory Committee and 12th Biannual Tribal Consultation session. It's an honor to come before you today. I've been in this acting position for about four months, and I've been looking forward to actually meeting all of you and participating in today's meeting. I'd also like to thank and welcome our CDC/ATSDR colleagues who is representing their respective divisions today and throughout the next day or so. I'd also like to specifically thank Chairman Antone and Co-Chair Lt. Governor Keel, who has provided some very good guidance for me over the last few months. I've had some good counsel, so thank you both for guiding me along. And there are five people in this room that I would like to specifically recognize, who seriously, we would not be here today, and that's my Tribal Support Unit staff. I'll mention Annabelle here in a little bit, but I'd like April and Miatta and Alleen and Deon and Romana, if you would please stand. So thank you, everybody.

(Applause)

There's so much work behind the scenes that goes on to pull off this kind of meeting and folks that traveled from Alaska to California and all points in between. It was quite a journey so thanks to the fab five for pulling that together. Just some quick logistics before we start the meeting. The closest restrooms are out this door and to the left. There's further ones around the corner – keep going to the right. In the event of an emergency, this is a shelter in place area, so if we need to, we can stay here. If we do need to evacuate the building, we'll go out the double doors and out the double doors to the parking lot. And for lunch, downstairs, there's an area, which probably is, I think, the only option for the time that we have, so for folks that are not CDC/ATSDR employees, CDC employees will have to escort you there, but there's plenty of us here, so I'm sure we can make that happen. So at this time, I'd ask you to direct your attention to the screen and just go over some basic protocols to be followed over the course of the next couple of days. During the meeting and the formal tribal testimony, only Tribal Advisory Committee members and CDC/ATSDR senior leaders, and if space permits, other elected tribal leaders, may be seated at the table. Please silence or turn off your electronic devices. Members of the public must sign in at the registration desk that many of you passed on the way in, and you need to wear your name badge at all times. And we've, most importantly, I'd like to point out for folks to please not enter or leave the room during the opening and closing blessings and during the formal tribal testimony. And as a reminder to all speakers, please hit your little red button here in front when you are speaking. This meeting is being recorded for transcription purposes, and I was passed a note just now that – to also turn off your speaker when you're done speaking so – the staff think of everything, I'm telling you. And then lastly, there's a resource table here and there are also some exhibits from our CDC/ATSDR partners outside, so please stop by during lunch and breaks to learn more about their work. And with that, I'll thank you and look forward to a great meeting.

Tribal Advisory Committee Business

Councilman Chester Antone: Thank you, Judith and Joe Maloney. We will now turn in to the Tribal Advisory Committee business. I'm gonna call on April R. Taylor to take the roll call for us.

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April (Taylor) Blowe: Alaska area.

President Alicia Reft: Here.

April (Taylor) Blowe: Bemidji area.

Tribal Board Member Cathy Abramson: Here.

April (Taylor) Blowe: Billings area.

Council Member Patricia Quisno: Here.

April (Taylor) Blowe: California area.

Secretary Adam Geisler: Here.

April (Taylor) Blowe: Great Plains area.

Chairman Robert Flying Hawk: Here.

April (Taylor) Blowe: Nashville area.

April (Taylor) Blowe: Navajo area.

Ramona Antone-Nez: Here.

April (Taylor) Blowe: Oklahoma area.

Lt. Governor Jefferson Keel: Here.

April (Taylor) Blowe: Phoenix area.

Tribal Council Member Delia Carlyle: Here.

April (Taylor) Blowe: Portland area.

Joe Finkbonner: Here.

April (Taylor) Blowe: Tucson area.

Councilman Chester Antone: Here.

April (Taylor) Blowe: At large.

Council Member Leslie Sampson, Sr.: Here.

April (Taylor) Blowe: Thank you so much. Councilman Antone, we do have do have 11 out of the 14 filled areas here today.

Councilman Chester Antone: Thank you. Briefly, I will go over the- our roles and responsibilities which you are already aware of, and this is the tribal consultation, government-to-government consultation. And we are the Tribal Advisory Committee. We advise the TAC- the CDC on budget, policies, programs, guidelines, and we also inform CDC of issues that are important to Indian Country, and we are elected officials and/or are authorized representatives. In the guidance to public attendees, they're open to the public, welcome to attend meetings to listen to discussion and presentations, and you will be seated in the gallery. You will not be able to participate in discussions or presentations in accordance with the Unfunded Mandates Reform Act and the Federal Advisory Committee Act. Elected tribal leaders who are not TAC members are invited to participate in the Tribal Consultation sessions and may be seated at the table as space permits. Members of the public include CDC/ATSDR employees, other federal employees, and non-federal attendees. I want to convey those instructions or guidance; however, the- earlier in the tribal caucus, the TAC membership indicated that they do not have any concerns over inviting the technical advisors to speak should they have something that they really want to say; they will be welcome to the microphone to discuss whichever issue. And if you could please just notify one of your representatives, and it doesn't have to be from your area specifically, you're all equal here. So I wanted to just say that this morning. And then on the HHS meeting updates, I think that most of the folks here are aware of other committee meetings that go on periodically during the year for CDC Tribal Advisory Committee. I can report that we do make reports over at the Secretary's Tribal Advisory Committee. The Secretary's Tribal Advisory Committee wants to hear reports from the different agencies that do have Tribal Advisory Committees and so we- we here at CDC, Joe Maloney and Dr. Monroe provide those updates to the Secretary's Tribal Advisory Committee. And then we, we as the Secretary's Tribal Advisory Committee, we in turn report those to our tribes. A lot has happened at the STAC meeting and one of them being the continued effort to have states comply with the Indian Child Welfare Act. The other is the Mental Health agenda for the American Indian Alaska Natives. A concern that came up from a former member here, Mr. Cadue of Kickapoo, who brought to the attention of Dr. Frieden, the violence occurring within the native population. As you know, the shootings in California and the shootings in Washington State, and I believe South Dakota had an incident, and that became a matter of concern, which led to the mental health agenda proposal to the Secretary as well as to all the agencies that were present there, and that will be something will be- that some folks will be working on. And those are just two of the items that I can recall. I do have the letter that NIHB drafted to the Secretary with all the concerns that came up in that meeting. So that's just a few of the highlights, I would think. The Health Research Advisory Committee will be meeting in the summer. That's to advise the Department of Health and Human Services to fund whatever research issues that need or exist among tribes or that tribes want to do or at the national level

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that should be done for the tribes as a whole. That – that advisory committee exists as well to discuss those issues. The other is the OHREG. One of the things that did happen there is that the National Children’s Study has been cancelled. For a long time, the Health Research Advisory Council was wanting to have the native populations over-sample because we are such a small sample that we won’t make too much of a difference or we won’t get too much out of it. So during that time, the Health Research Advisory Council has- had been trying to get a study conducted or to add us. However, there, I don’t know, equations you might call them, statistical equations, were already formulated to that population they were looking at and the only way that would work was to do a study on the side to complement, but that has since been cancelled. But that is just a little example of some of the work that Health Research Advisory Council does. SAMHSA has come up with a Tribal Affairs Office, it’s called the Tribal Affairs Office, much like the OSTLTS Tribal Support Unit, and that is kind of, I believe the third or fourth agency that has created an office specifically for native issues, and which is pretty good because as you recall back in the 70’s, early 70’s, we had what you would call an Indian Desk, the agency’s desk clerk manned by a person, and you would go there and some of you more mature folks probably remember that, and it’s a really nice development that it has now gone beyond that due to tribes’ lobbying efforts and discussion overall nationally that certain agencies are now beginning to realize that tribes do need a place in the system. So the CDC, SAMHSA and I believe the Justice Department also has one. So we’re moving. Maybe small steps but we’re getting there. And I wanted to just provide those HHS meeting updates as I know them. I do have a copy of the issues from the STAC that were sent up to the Secretary Burwell, and I’ll have that available as we make copies. And so just briefly, that’s a brief update on that, and we’ll discuss the 2015 TAC meeting and Tribal Consultation session; I believe we’re heading to Portland area. And April, do you have any other details on that session?

April (Taylor) Blowe: You are correct, Councilman Antone. The meeting will be in the Portland area, hosted by Council Member Andy Joseph, and we are checking into hotels. We’ve already checked into the recommended hotel, Northern Quest, and we will provide additional information, travel, as- next month. We’re looking at August but whatever dates that you all vote on we’re gonna go with those dates. So far, the hotel does not have any conflict with August or if you want to have it in another month, but they’re pretty open right now. You’re welcome.

Councilman Chester Antone: Thank you. As you know, when we have our phone calls, teleconferences, we usually decide on the days. We polled the TAC members to see if- when they might may be open for a meeting and then we use- we use the teleconference to do that so we all agree on a meeting. A meeting is usually the TAC meeting and then the consultation, and then usually a site visit, and that will be planned by the local planning committee should they come up with one, and if not, then we- some of us may have to take the initiative to contact, or we could have the TSU, Tribal Support Unit, do that. And this is information for you. And regarding the minutes, we have approved them. We have a quorum approving them and that was done by email so April has a record of the approvals that were emailed in from the 2014 Michigan meeting. And I believe that- that is the conclusion of the Tribal Advisory Committee business. At this time, I’m just gonna kind of ask the committee is there anything that you wanted to ask or

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add on, and if not, we can move on. Everybody okay with that? Okay. So we do have a break scheduled for 10:50, but I would just maybe like to go on to Mr. Maloney. As you know, we discussed the budget this morning so we want to be able to make sure that we have time for that. So go ahead move on, Mr. Maloney.

CDC's Tribal Support Unit Update

CAPT Joe Maloney: So thank you, Chairman. I'll provide a Tribal Support Unit update, and I would like to start off to my right for a person that we have not heard from yet. And someone that many of you know and that's Ms. Annabelle Allison. So Annabelle, you want to do a quick introduction?

Annabelle Allison: (Greeting and introduction in Navajo) Good morning, everyone. My name is Annabelle Allison. I am a member of the Navajo Nation, originally from New Mexico. I've been here at CDC/ATSDR now for about 6-1/2 years. I'm really happy to say that I just joined the OSTLTS Tribal Support Unit staff officially this past month in January, and so I'm really excited to be in this new role and I'm hopeful that I will get to maintain the environmental health portfolio that I've always had with me since I've been here and I'm also looking forward to working with Dr. Monroe and the TSU staff and all of you on the bigger public health topics as well. So thank you.

CAPT Joe Maloney: Thanks, Annabelle. We're just really excited to have Annabelle join the team and this is really a strong addition to the Tribal Support Unit. Continuing on with our staff, we have Ms. Delight Satter, who serves as a senior advisor for the Tribal Research and Program Integration. We have April Taylor who now goes by the name of April Blowe because she got married last summer. Congratulations, April. For those of you who wondered where April was the last summer TAC meeting, she had an excused absence. And we have Miatta Dennis, and I'm sad to announce that this will be the last Tribal Advisory Committee meeting for Miatta, but in a good way because she has accepted a promotion and will be joining the CDC Office of Global Health. So congratulations, Miatta.

(Applause)

But before Miatta even gets a chance to join Global Health, she will actually be departing to Liberia. She will be deployed to her family's home country of Liberia for the Ebola Deployment Response. So it's not only a professional journey for Miatta but a very personal one and we wish you good luck with your work, Miatta. And then lastly, I'd like to reintroduce our three Public Health Associate Program folks, and that's Deon and Romana at the table there and Alleen, who is hiding way in the back there. They actually graduated from the Public Health Associate Program this past July. They have been an invaluable addition to the team. Great to have them. And as a side plug, we have lots of good information about the Public Health Associate Program outside, so I encourage all of our tribal members to learn more about that. To continue on with a couple Tribal Advisory Committee updates. I'm very pleased to welcome our newest TAC delegate and that's Secretary Adam Geisler from the California area. Secretary Geisler, thank you and thanks

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for joining us. And we have our authorized representative from the Portland area, Executive Director Joe Finkbonner. So thank you, Joe, for being with us today. And we currently have two vacancies on our Tribal Advisory Committee. We have a vacancy for the Albuquerque area and we have one at-large member to fill that vacancy. So we will proceed with advertising, trying to get those two positions filled immediately following this meeting actually, so if you could work your networks and see if we can get two great additions to our Tribal Advisory Committee. And then I'd like to just mention that we are continuing to work on our TAC engagement plan. This is a continuing effort to improve our clear and effective lines of communication with all federally recognized tribes. Some recent updates to the Tribal Support Unit as Annabelle just mentioned. She's joined our team here at Tribal Support Unit. A strong addition to the team. This is going to really help maximize our efforts from CDC and ATSDR in Indian Country. So just really pleased to have Annabelle's expertise. OSTLTS is in the final stages of identifying a permanent associate director for the Tribal Support Unit. We anticipate that happening, the announcement, in the next couple weeks or so. And then just to mention that CDC has a cooperative agreement with the National Indian Health Board and part of that work includes the development of the Tribal Public Health Work Group to provide technical assistance to our TAC members, and the Tribal Public Health Work Group had a meeting yesterday and several of the CDC folks, my colleagues, participated in that meeting. Great meetings. Great way to jump into that work with the National Health Board. So we really look forward to strengthening that partnership with NIHB in that work and related efforts going forward. I'd like to share with you just a few examples of how CDC and the Tribal Support Unit have partnered with our other federal partners and operating divisions. Early in the Ebola response, CDC partnered with the Indian Health Service in conducting part of their clinical rounds. The Indian Health Services Chief Medical Officer holds monthly clinical rounds and so there was already an existing mechanism with far reach throughout Indian Country, and this really kind of evolved organically just like the first week I got here I think, and was on the phone with some Indian Health Services colleagues and as we were kind of finishing up that unrelated conversation, they asked, you know, "do you have a link to your emergency operations folks to provide Ebola updates for us during these rounds?" And I said, "Yeah, I'm at CDC, I think we can make that happen." So we did reach out to the Vulnerable Populations Desk that's at the Emergency Operations Center and we had Commander Maleeka Glover. I don't know if Maleeka is here. I'd love to have her stand up because she was awesome. She jumped right on board. I mean literally a couple of days later was their next call and Maleeka had about 30 minutes that she provided Ebola updates. And then as the response quickened and intensified, they bumped those rounds up to weekly updates so we were able to keep that connection and just keep people informed as we moved forward. So that was a great opportunity with IHS. I also wanted to mention some recent collaborations with SAMHSA, the Substance Abuse and Mental Health Services Administration. We began work with them regarding the issue of illicit drug use among pregnant women. This was an issue that was originally brought up to us from the Northern Plains Tribal Epi Center, but we all know what a huge public health problem this is throughout Indian Country. And this is an effort, this is a continuing effort. We've been meeting I'd say about every other week. We've expanded our reach both internally. We've had folks from our Division of Reproductive Health, others that I'm sure I won't be able to name. But outside of that, SAMHSA was able to reach out through their networks and bring several people to the table, and as part

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of that effort, we've also become aware of partners such as Bureau of Indian Affairs, who work directly with incarcerated women, and the Bureau of Justice, which coordinates vocational and educational programs in the jails. So just an example of how, you know, working through our partners and becoming aware of the resources that are out there to address this critical public health issue. Want to just briefly mention the National Institute for Occupational Safety and Health, NIOSH, and they'll be presenting information to you later today, and this is their worker safety and health initiative for American Indian and Alaska Natives. And then lastly, just wanted to share that folks from the National Institutes of Health recently reached out to the Tribal Support Unit here at CDC. They're in the process of setting up their own Tribal Advisory Committee, and it was a great collaboration just, you know, why reinvent the wheel if they know that folks have been doing this already. So our whole group was able to sit on a call and just kind of talk through the process and how to help them in their early stages of setting up their- their TAC. And I think with that that is the Tribal Support Unit update. Chairman Antone.

Chronic Disease Prevention and Health Promotion in Indian Country: Current Initiatives and Future Directions

Councilman Chester Antone: Thank you, Joe. And we are very far ahead. I think since we're way ahead of time, we'll go ahead and entertain Ursula Bauer if she's ready for us from the Chronic Disease Prevention & Health Promotion in Indian Country: Current Initiatives and Future Directions. Ursula Bauer.

Dr. Ursula Bauer: Thank you very much. I do have slides. I'm hoping those will come up. Great. Thank you. Grab my notes here – wasn't quite ready. So welcome. I really appreciate the opportunity to speak with you this morning. I'd like to provide an update on the activities of the National Center for Chronic Disease Prevention & Health Promotion, and then perhaps we'll have time for some discussion and I can obtain some guidance and advice for where we head in the future. So I'm please to say that, since we last met, the National Center for Chronic Disease Prevention & Health Promotion has increased our investment in Indian Country by 60%. That's an increase from \$21 million in 2013 to \$24 million in 2014. Your handouts may say 21 million – I'm sorry, 31 million, but 34 is the correct number. And that increase is primarily driven by a new program, Good Health & Wellness in Indian Country, that represents more than a \$13 million investment, and I'll be talking about that program in more detail in a minute. That 60% increase is in spite of the on time ending of the Community Transformation Grant Small Communities Program, which was a \$2 million investment for two years, and the on time ending of the Traditional Foods Program, which was a \$1.5 million investment, and also the premature ending, the two-years early ending of the Community Transformation Grant Program as a whole which was another \$2 million investment in Indian Country. So those programs all went away, but we still manage to increase our investment quite substantially. In addition to Good Health & Wellness in Indian Country, we also have the new community health program, Partnerships to Improve Community Health. We have some 40 or more grantees across the country, including six awards to tribes or tribal organizations totaling over \$4 million, and we have the new REACH

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program, Racial & Ethnic Approaches to Community Health, that also has about 35 awardees, including three to tribes and tribal organizations totaling over \$2 million. Most of our flagship programs in Indian Country have remained and those are mostly at-level funding so our Breast & Cervical Cancer program, Comprehensive Cancer program, the Colorectal Cancer program and a number of others listed here on the screen. These are critical effective programs supporting great work in Indian Country, but they don't meet the demand and we recognize that. We fund a variety of cancer, heart disease, community health and diabetes programs, but our approach has been scatter shot across Indian Country; a cancer program here, a diabetes program there, a community health program in another place, and that makes it very hard for us to make progress for the population as a whole. And so this year, with Good Health & Wellness in Indian Country, we're trying a more coordinated and comprehensive approach to get a critical mass of resources and support focused on chronic disease prevention and health promotion. Our diseases and risk factors are very interrelated, they're biologically connected, they cluster together and our strategies to combat them are often similar across programs. So we're trying a new approach to deploy a cohesive and more comprehensive set of strategies with our resources driving toward a small set of health outcomes that get at the major risk factors for chronic diseases, specifically commercial tobacco use, obesity, diabetes and heart disease. While we'll continue to fund those flagship programs, the cancer programs and community health programs, our new model gives us a better opportunity to reach more deeply and widely into Indian Country, and it offers an opportunity for growth and to increase our impact that's not dependent on a one-for-one increase in funding, although additional investment would be required. The approach was developed through consultation, through dialogue and through visits to Indian Country. We sought advice from this body over the past four years. We've had discussions about how to approach our Chronic Disease Prevention & Health Promotion work in Indian Country. We visited a number of Indian lands and met with tribal health leaders. Of course, Indian Country is very far flung and we've spoken with only a tiny fraction of tribal health leaders, but we sought to create a program that tribes could make their own and that could succeed in reversing the epidemic of chronic diseases in Indian Country and have that potential for expansion. So Good Health & Wellness is that program funded, as I said, at nearly \$14 million a year from the Prevention & Public Health fund. It takes a three-pronged approach funding 11 tribes, 11 tribal organizations, and 11 tribal epidemiology centers. The tribes that are funded directly design and implement a suite of community-chosen, culturally-tailored interventions that make it easier for people to do the healthy behaviors and focused, as I said, on reducing obesity, diabetes and heart disease. The tribal organizations—and at this point we funded one in each of ten IHS administrative areas, we're working on expanding that number. The tribal organizations work with the other tribes in their Indian Health Service administrative area in order to build the skills and experience implementing one or two of the interventions that the tribes funded directly will be implementing the tribes funded directly implement a much larger number. But as these other tribes in the area, with the support of the tribal organization, gain experience and know-how with the strategies, they can grow and expand the number that they're implementing and address a variety of chronic diseases. And then finally, the Tribal Epidemiology Centers develop their own capacity and expertise to serve their tribes' public health needs; needs for surveillance, for evaluation and for services, and assist the tribes and the tribal organizations with evaluation of

the program. The 11th Tribal Epidemiology Center funded through this program is the Urban Indian Health Institute in Seattle, and we're working in partnership with them to coordinate an overall evaluation of the program. So Good Health & Wellness in Indian Country seeks to deploy effective culturally-adapted strategies that rebuild a culture of health in Indian Country, that reconnect tribal members to their cultural values that foster a rediscovery of healthful traditional foods and beverages and active ways of living that make us strong. It's a program that empowers people to take charge of their health and then gives them the wherewithal to do that. Right now, we're at the beginning of the journey. It's a- there's a tremendous amount of enthusiasm and excitement among our grantees and I look forward to briefing you over the next five years and sharing with you the accomplishments that we'll be able to demonstrate from that program. Because the know-how to reconnect with cultural values and to reconnect to a culture of health exists in Indian Country, the ability to tackle chronic diseases resides in Indian Country. We are creating a community of practice among the 33 grantees of the program Good Health & Wellness in Indian Country, and we'll be tackling chronic disease prevention and health promotion issues as a team. The approach is based on Project ECHO, which is Extension for Community Health Outcomes. It's a program that was designed at the University of New Mexico. Our grantees gather twice a month in a video format, and that's what you see in this slide. That's a screenshot from one of our ECHO sessions. We're all on the video screen together. We're looking at each other, we're reading the body language, and we're paying attention to who's looking down at their Blackberry and who's engaged in the conversation. And we're building this community so that we can identify very quickly the things that are working in one area and disseminate those out to the other areas, and so when we have common problems, we can bring them to the table and work on solving them together. So, again, we're in the early stages of this program. We had our kickoff meeting just last November so we're only a few months into it, but we believe that using this ECHO approach will really magnify our ability to find those solutions, to work together, to share our experience and our solutions. So we're very excited to launch this program and look forward to sharing more about it with you. So that was a snapshot of the Good Health & Wellness in Indian Country program. As I said, my expectation is that it will be a very effective program with hard health outcomes to be delivered. As I've met with grantees over the last several months, we've agreed that the bar has been raised very high. We're all excited about striving to achieve health outcomes and looking forward to jumping into the work. Before I turn to the other bullets on this slide, maybe I'll stop and see if you have any questions or comments about the work of the National Center for Chronic Disease Prevention & Health Promotion.

Councilman Chester Antone: Any questions from anyone?

Secretary Adam Geisler: Thank you, Mr. Chairman. Dr. Bauer, I really want to commend you on the work that you've accomplished so far and the outreach that you've put towards Indian Country, and I really do appreciate the efforts that have been made in the increase that you mentioned coming from 21 to 34 million. But one thing I would like to try to understand a little bit more. There's a lot of discussion in Indian Country about how do we become more competitive for the funds that are out there and instead of being a person that just is going to say we need more money, I'm going to say above and beyond that I'd like to understand how do

we become more competitive so we can get to the dollar? You've obviously been engaged in this for quite a while and reviewed the applications and seen what they are- what the positives are and what the negatives are and what they're lacking to be competitive. So I'm wondering if you could share a little bit about some of the issues that you're seeing in our ability to be competitive for the funds.

Dr. Ursula Bauer: So with advice from the TAC, we have sought to create a situation where tribes and tribal organizations are not competing against state and local health departments, for example. So Good Health & Wellness in Indian Country, of course, was a funding opportunity that only tribes and tribal organizations could apply for. For the Partnership to Improve Community Health funding opportunity, that was open to a whole range of applicants. Not state health departments but local health departments, community-based organizations, tribes, a whole range of applicants. And what we did in that- in that funding opportunity was have tiers or categories, so we'd fund some number of larger communities, some number of smaller communities, and some number of tribes. And so, again, tribes would be competing against each other rather than competing against the entire universe. And then for a program like REACH, Racial & Ethnic Approaches to Community Health, that was an open competition. Everyone was competing against each other. Tribes were competing against locals, were competing against community-based organizations and so on. And in that REACH award, tribes and tribal organizations received three awards, and I believe that was about 10% of those awards. So I would say you're doing quite well in that open competition. In the Community Transformation grants, if I remember, we funded six tribes or tribal organizations, and again, that was about 10% of total awards. So very strong success in terms of the competition. When you think about the dollars that my center puts out the door each year, upwards of \$700 million and only \$34 million is going to Indian Country, that's because it's a very big country, and we try to make sure at a minimum we're funding to the proportion of the population, which is 2-4%, and that's where we land each year. In discussions with Dr. Frieden, of course, the burden is greater than the representation of the population, the proportion of the population and so how do we increase the investment to recognize the burden of disease, especially chronic disease in Indian Country and that's where we would look to our funder for dedicated funding for prevention activities in Indian Country.

Secretary Adam Geisler: I just want to make sure that I heard you correctly. So basically what you're looking at in terms of the way you're trying to be fair with disbursement really boils down to population-based scenario that you're looking at in terms of Native Americans and Alaska Natives in proportion to the rest of the country. I guess one thing that I would suggest for yourself and for the rest of the group in your review is that oftentimes, there are other sources of revenue to support these types of activities that are already ongoing in terms of states and local communities, and one thing to keep in mind, because I understand it's not an easy thing to do and obviously as I said, we always would like to see more dollars, but one of the reasons why I'd be asking for that is because we don't have a tax base in my community. We don't have—I'm in southern California, we're not all gaming tribes, we're not all rich. You know, some of us do have limited resources and that's my community. And so I just wanted to plant that seed with you

that, again, I recognize and appreciate the approaches you're taking, but I would also ask that you consider taking that maybe one step further in the way that you address that because these a lot of times are the only sources of funds for prevention. You know, I'm seeing the whole list here, you know, cancer, all of it. And so, you know, and then obviously under the new healthcare legislation, a lot of my community is opting directly for the services that are coming out and a lot of times as you're coming through our health clinics as a sub-grantee or contractor of these awards, so I just wanted to put that out there to you and thank you for your explanation. Thank you.

Dr. Ursula Bauer: I would just clarify that the percentage of the population is the floor, it's not the ceiling and so we do strive to increase that amount, and we have, you know, slowly but surely inched it up. I'll just also note that 75% of the dollars that this entire agency puts out to Indian Country, this entire agency of a dozen or 15 centers, 75% of those dollars come from my center. So there are other centers that can stand up as well and pay attention to Indian Country.

Councilman Chester Antone: Anybody else want to ask any questions? You had another—

Dr. Ursula Bauer: I did have a couple of other points. This is where I really wanted to put a couple of issues on the table and hear from you whether they're issues or not, and if they are, how we might proceed. I like to have a longer term vision of what I need to do so that as opportunities arise, I can try to seize them and deploy them toward making progress and filling gaps. So a couple of issues that have come to my attention over the last couple of years are first, how do we address urban Indian health, and it's been brought to my attention that many American Indian/Alaska Natives are not on the reservation, are in areas across the country and that may be a population that we're missing as we fund tribes and tribal organizations, and how should we think about reaching that population as well as reaching the population on tribal land. So that's one issue I'd appreciate your guidance on. The second is it's one of CDC's priorities to work more closely with healthcare to bring public health and healthcare together and work in that space where we have some mutual interests and this is an area that we've moved forward with pretty aggressively in collaboration with health systems and with state health departments. We have not addressed it as much in Indian Country and I'd like to hear your thoughts about whether and how we might proceed with working with health- healthcare systems to focus more on population health and community health. And then the last issue Chairman Antone mentioned as well, it's one that keeps coming up again and again, and this is mental health. And that's not an area that my center has worked in but it's one that we come up against again and again as we seek to address chronic diseases, and it's often a barrier toward preventing diseases, effectively managing diseases, and so my question is, is there a role for CDC, is there a role for the center and how might we begin to think about tackling mental health. So those are the three issues that I wanted to tee up and if there are any others, I'd love to hear your thoughts and guidance.

Councilman Chester Antone: Does anybody have a comment?

Dr. Ursula Bauer: I thought we could maybe solve them all before lunch.

Councilman Chester Antone: I do have a comment on the mental health. And this is – has- Dr. Monroe knows we brought up over at the STAC meeting, and trying to think about what we could do for – what we could come up with as an agenda for behavioral health in Indian Country that we could try to pass in this administration knowing that it's uncertain what that administration will look like after the election. But wanting to get something that's kind of consistent or made up of some commonalities between or with all tribes and those will be the kind of like the building blocks, I guess you would say. And that would include like, you know, almost every tribe has creation stories that teach morality and values, and that's certainly one of the common themes that run throughout tribes, the coming of age in traditional and cultural aspects, how special that is and rites of passage, and defining native ways of worship to the creator, commonalities that exist there and the role of the male and the role of the female, the celebration of birth, etc. And so if you look at the community approaches to mental health and your role in the overall community of mental health not specific to these tribes but overall, I think that the CDC's role are many to contribute to this agenda because part of this agenda for those things that I mentioned are something—some of those things are those things that don't quite mesh with your evaluation forms—and that little box, check off. My suggestion will be if there is no box to check off to write about it, why? Because that would certainly help Indian Country.....traditional healing CMS has a role for reimbursement. In fact, the CDC might want to consider any funding that you have that may be might be laying around, or you don't- or that you ask for and don't know quite how to use it yet that may be issued to put some of that into a grant form that'll help the entire native community discuss these examples of what I – what I pointed out, as that agenda to pass on to the next administration and the next administration because in a sense, you're defining the native population, what we would define our population as far as the common themes that we have. One of the common themes is the use of the eagle feather- that's universal, not just in- in the U.S. but internationally; spirituality very hard to gauge and yet that's one of our- our main tenets that we go by, as far as mental health is concerned. But assistance from federal agencies to evaluate that. There is friction because the federal agencies don't want to change, we don't want to change. So somewhere we have to meet to agree on how we're gonna—how you or what you will require and what we require. A lot of times those are things that we want because we know it works but in CDC's eyes, that's some mystical thing, some ritual that we do and yet for us it's real. So those differences, I think, really need to be discussed in the overall community and also in that specific community. Federal agencies just need to have an ear and believe what we're saying is true. So I have to speak louder. So to me this is one of the—I won't say project but just open discussion to really to- to get at what we really need is- too often we have one organization doing this, one tribe doing that, one tribe doing that, but we don't really have an agenda that covers all of it. It's really an identity for the native population because a lot of concerns are that the tribes are losing some of their traditions, their values. We do not have to define that for—we do not have to tell the tribes this is what you need to do, we just—these are the common things that exist in all of us and we need to focus grants moving forward to these tenets that exist and so it's kind of uniform overall. I would just offer that because really that comes on the heels of Obama's directions to his staff, and I think that includes all federal agencies and it's stated that the White House to go out to Indian Country and see for yourself.

And I was- I was over there at the White House conference and I heard him say that, so I piggyback off of that. SAMHSA is also gonna be approached at the HHS consultation. Gonna say basically the same thing I'm saying here, so it goes around to all the federal agencies that I will consult with on a one-on-one basis but also at the HHS consultation, BIA, BIE, Justice. Everything is kind of like a way become—to me anyway when I look at it is – it's really big and sometimes I kind of don't really know how we're supposed- how to approach that but I know that people do know and will jump on as we move. So I offer that much for the mental health and the CDC's role. As I said, it's a big role that CDC play. Public health and healthcare. Public health and healthcare I would think comes from not only emergency situations but as a matter of forethought. If we know what- what exists in healthcare overall or even from the IHS and we seek to collaborate in a public health way, we- a lot of that is gonna hinge on a word that I'm pretty sure everybody hears and there it goes again—communication. Because when we do that and we find out what the healthcare is in general and how that healthcare can be, in a sense prevented, serious health issues, in a public health way—I forget what I'm saying. I don't even know if I get what I'm saying but there's kind of two different things I would say. One of them is to help prevent those situations that require healthcare, then there are healthcare matters that public health needs to address. That's the best way I can say it. In addressing urban Indian health, the first discussion that I made, that encompasses urban Indian health because we're the same. But because we have to work in town, because we don't have that economy on the reservations—some do, some don't—that requires us to follow the work...in towns, but they come from home and so there's not a whole lot of difference there, I don't think. It's getting to healthcare that's the problem many times. Sometimes I have to count on Medicaid and its benefits for transportation. Those sort of things. Public transportation but really it's- I think we all have common themes and I think urban Indian health can be pulled into that. That's my spiel on the whole thing. Joe?

Joe Finkbonner: Thanks, Chester. Dr. Bauer, I'd be remiss if I didn't thank you for all your travels out to Indian Country to talk with the area health boards and the tribes about how to approach chronic diseases in Indian Country. I- my hands go up to you for reaching out to Indian Country and to create these new resource opportunities for tribes and tribal organizations, of which we're one of the organizations that benefit. So thank you. I want to give you some feedback on the three bullets that you're specifically asking, and I can't speak for the other areas, but in the Portland area, we have three urban groups in Seattle, Portland and Spokane. Our organization works well with all three of them. We either do something with Portland. In NARA, we did a SAMHSA grant and we worked with NARA on a community outreach SAMHSA grant. Seattle Indian Health Board, we work with on our epi center. We've also done some other things with them programmatically and then the native project in Spokane, we've also done some epi work with them as well. The one thing that I will say is that there are some subsets within the urban population that continue to go back and forth between the urban centers and the reservations, but there also is the Urban Indian population in the northwest that just tends to stay in the urban setting and doesn't do that migration. They tend to be folks from—their tribe tends to be from outside of the administrative area, so we'll have some Sioux members and Navajo members that live in Portland and Seattle and Spokane that just tend to stay there and don't go visit the reservations much, unless they need care that they can't afford elsewhere. So it's really the

access to care that gets them into the reservations or the—but we have that good relationship with the urban programs, so we'd love to brainstorm ways that we can work more directly with our urban programs because they're good partners and we would like to foster that relationship. Two and three I want to combine a little bit and that is that the Indian health system really is a good model for looking at public health and healthcare delivery because it really has blended public health and healthcare delivery for- since its inception back in 1955, and that is partly to blame why I think tribal leaders really have a hard time grasping what public health is because they simply went to the clinic, which had public health services, as well as, you know, their own individual medical care and that was blended. And so I think that the Indian health system is a good model to look at in terms of how that collaboration can take place and whether that's stationing public health folks within clinics which is a little more difficult to do in mainstream medical system, but- and certainly close systems like the Indian Health Service, or Indian health system, I think that's a model that works well. And part of that are the mental health. If you're gonna deal with things like, you know, prescription drug abuse, which I saw in some of the notes here, certainly those are all hand in glove with dual diagnosis folks that go to our treatment centers. They usually come in with depression and a substance abuse issue, so it's not one or the other. It's oftentimes our programs are dealing with folks that have a substance issue and mental health issues at the same time, so I think it's – I commend you for trying to take that approach and combine them and look for a role that CDC can get more engaged in. And what I offer you is that there are oftentimes many cultural events that help to blend the mental health and public health profiles together and the model that I'll talk to you about are actually a couple. Is- in the northwest, we have an annual canoe journey, which is the month of essentially July—actually the month of June beginning into July and- where the tribes that's from mid-point of British Columbia all the way down to southern Oregon, there'll be a host tribe that hosts a potlatch and they schedule it for a week-long celebration and all the tribes from those various coastal communities will then get in their canoes and paddle and it's called the Paddle or Canoe Journey. And sometimes the furthest tribe out—oftentimes that's Bella Bella which is in central British Columbia, has to be in their canoe for a full month to paddle to the host site. And in that tribes will host them along the way in their journey and they get together. There's a strict protocol that's very cultural. The host tribe will feed the members that come there, they sing songs, and they tell stories. But how it combines, that's very much a mental health renewal as well in that whole and giving- living your culture like we used to, but also it's very much a public health effort and they don't just jump in it for that month and do it. They've been training all year long to be able to get to that point and that's just good public health. They eat right, they exercise and so they're doing it, and I think that if you can find models where you combine the- our cultural practices that- and develop those more into public health activities, you're gonna have something that's really sustaining. And the canoe journey has been going on for a number of years now, and it started off with just a handful of canoes in the northwest to now it's- we have up to 100 canoes that will show up at the final destination and ten to fifteen thousand people that will be there. And great opportunities for public health intervention as well when you have ten or fifteen thousand Native Americans walking around and you can really capture them and talk with them. But they- if you haven't had a chance to see the canoe journey, I would invite you to look that up

either electronically or certainly come out and again and see one of these in action because it truly is a wonderful site to see.

Councilman Chester Antone: Thank you, Joe. And we're almost to the lunch break so I'll entertain another one.

Ramona Antone-Nez: Thank you, Chair Antone and Dr. Monroe and members of the TAC, and Dr. Bauer, thank you for your commitment to Indian Country. Recall about three years ago through the CDC TAC, we had the opportunity to visit the Makah Nation. I remember sitting in a long house and an elder spoke of the many needs that they have in their community. I recollect that she said about 2,600 members of her nation and she said, we're not like the Navajos. The Navajos, they're everywhere, she said. And based upon that, I remember her saying that because there was four of us sitting in front of her, and according to the census 2010, there's approximately 332,000 Navajo. Of that, about 53% do not reside on Navajo Nation, which brings me to the Urban Indian. As stated by the Makah elder, the Navajos are everywhere and if we're not, we're coming to a town near you. So what I mean is that I think the Urban Indian population will continue to increase due to the social determinants that we do face on Indian land. So what I want to let you know that is that is one of the issues that we're faced with. The other is about the Good Health and Wellness in Indian Country, about the chronic illnesses, about heart disease, diabetes, and stroke. They all have that interconnection with mental health and how do the current grantees address that now, because there's the dual diagnoses and the effect of not only these chronic illnesses but also how does alcohol play a role in how we address the chronic illnesses as well as mental health as it relates to unintentional injuries and the effects across the lifespan of- of a person. So I just want to bring that to your attention that- in an appreciation that there is the need to address the public health and healthcare as we've become more self-determined, as well as we become more urban-based and just want to encourage that the process to address mental health is- is huge, and that also has implications to suicide rates just across the spectrum. A huge public health issue that you have brought forth to ask for input. Those are my statements at this time. Thank you.

Councilman Chester Antone: We are at 11:27 and we're scheduled to take a break at 11:30, so if there's- isn't anything burning at the moment, I wanted to invite Romana to give us a little wrap up for the morning session and then we'll go on break. And thank you very much, Ms. Bauer.

National Institute for Occupational Safety and Health: 2015 Updates

Councilman Chester Antone: Good afternoon. Thank you for coming back at 12:30. There's been a change in the agenda, mainly due to us wanting to have that budget presentation. So what's gonna happen now is we're going to move the National Institute for Occupational Safety & Health update for- for now and then following that presentation, we'll go into the CDC Tribal Motor Vehicle Injury Prevention Program. So we're just turning those two things around and then after

that we'll get right into the budget. So if I- if I may, I would like to call Elizabeth Dalsey and Constance Franklin from the National Institute for Occupational Safety & Health.

Elizabeth Dalsey: Good afternoon. Thank you all. Thank you for the opportunity to speak. We're very happy to be here today, especially after lunch. I'm Elizabeth Dalsey, this is Constance Franklin. We're from the National Institute for Occupational Safety & Health (NIOSH). Before I get started, I wanted to provide a quick overview of what we'll be discussing. We'll provide a quick overview of NIOSH, the National Institute for Occupational Safety & Health, talk about what we do, and go over some of our activities and programs, and then we'll talk about Total Worker Health, which focuses on health protection and health promotion. Then we'll talk a little bit about young workers, the impact work has on youth, talk about our Young Worker Curriculum and then talk about our work with the organization "We R Native." And then lastly, we'll spend our time, the majority of our time talking about our tribal initiative and our workshop that we're planning for this summer and fall. And just a reminder, I think in the binders you all have slides and there are some handouts about some of our programs and there should be a document with some questions that we hope to address today. So thank you.

So just an overview about NIOSH and thank you to Dr. Monroe—Captain Maloney for addressing some of our initiative. And I apologize, for some, this may be repetitive as we presented at the 2012 TAC meeting, but I did want to provide an overview about NIOSH. The Occupational Safety & Health Act of 1970 created both NIOSH and OSHA, the Occupational Safety & Health Administration. And the goal of these organizations was to assure safe and healthy working conditions for working men and women. This diagram here shows the creation of these organizations, and on the right-hand side, you have NIOSH and this organization was set up for research and recommendations. NIOSH is under the CDC, we're officed under the CDC and we are all part of Health & Human Services, and on the other side, you have regulation and enforcement and consultation, which OSHA is responsible for, and they are under the Department of Labor. For our discussion today, we'll be focusing on NIOSH and the work that we do. We are the federal agency that's responsible for research for worker safety and health, and our mission is to generate new knowledge in the field of occupational safety and health and to transfer that knowledge into workplace practices to prevent work-related injury, illnesses and death. NIOSH is geographically disbursed. Our headquarters are here and in D.C. I work in Denver and we do work to prevent workplace safety and health. There are 9,000 U.S. workers that sustain disabling injuries every day, 16 workers die from injuries and 130 die each day from work-related illnesses. There are a total of 155 million U.S. workers. There are roughly 1.9 American Indian and Alaska Native in the workforce. That's roughly 0.8% of the total U.S. workforce. NIOSH has worked with various tribes in different industries. One way we have collaborated is through our Health Hazard Evaluation program. This is a free program. It's a great program. NIOSH can come out if an employee, an employer is concerned about a hazard in the workplace. If they have a concern, an area that they're worried about, we can come out and take a look at that further. A couple instances where NIOSH has come out and worked with a tribe, we've looked at aquaculture, so how the tanks are being set up, and looked at personal protective equipment, material labeling, so how the hazards are being labeled, and also confined spaces. We've also

done work with dental offices and musculoskeletal disorders. We've also worked with tribes and casinos looking at dust control and noise with how the money is being sorted. And so we've worked with tribes in that capacity. NIOSH also has a state-based surveillance grant. This is an ongoing grant for the next five years. State is misleading because tribes are also eligible for this grant. It's established for surveillance programs to build capacity and occupational safety and health. The goal is to assess the extent and severity of workplace injury and illness and to utilize data sources. It's developed capacity within states, within tribes to take a look at the occupational safety and health profile within your state, within your tribe and it's a- a wonderful opportunity. Currently, NIOSH funds 23 states, and we really think it's a great opportunity for tribes and we love to work with tribes to utilize that grant. In addition, which - which was mentioned earlier, NIOSH in 2013, launched American Indian/Alaska Native Initiative to provide occupational safety and health support with tribal communities. Although we've worked with tribes in the past, this is a more concerted effort to really provide support and learn how NIOSH can best help tribes. We'll talk about this more later, but we'd really like feedback on how we can best work with tribes, how we can provide support and what are the needs of tribes. And we'll talk about that more later, but what we do know is that we have some baseline data on fatalities. We do know that between 2003 and 2010, an average of 37 fatalities occur each year with tribal- with tribes and that the top industries for fatalities occur in construction, ag forestry and fishing, and transportation, and the leading cause of work-related illnesses - excuse me, work-related fatalities is transportation. What we don't know is what are causing illnesses and injuries. So national data for injuries and illnesses we don't have much information on. So again, we'd really like your input on data sources, where we can obtain some of this data and, again, that state-based surveillance grant is a great opportunity to get more information there. So I'm gonna turn it over to Constance and she'll talk about total worker health, unless anyone has any questions about NIOSH or anything I've mentioned so far.

Councilman Chester Antone: You said state based surveillance systems. Is - does the state based surveillance- the NIOSH-how does that work with you and the states?

Elizabeth Dalsey: It's called the NIOSH State-Based Surveillance grant, and it's an ongoing grant system for the next-we've finished our first year so there's four more years left, and you can apply for the grant. I can send it out to the TAC, which I plan to do, and you would apply for the grant and then there's funding for an individual to help with the surveillance system and then the grant looks at occupational health indicators and so you can really get a sense of what the occupational capacity is within the state and it helps you collect that data there.

Councilman Chester Antone: It's a data gathering?

Elizabeth Dalsey: It's data gathering.

Councilman Chester Antone: Sort of a grant.

Elizabeth Dalsey: Yes, so it's to help you within a tribe look at data sources and what the profile is within your states. So it looks at hospitalizations, amputations, asthma, and things of that nature. Currently, there are 21 occupational health indicators that are collected to look at this grant.

Councilman Chester Antone: Okay. Mr. Geisler?

Secretary Adam Geisler: Thank you, Mr. Chairman. Just a couple questions for you. The first question is- is with regards to the statistics that you rattled off. Where can I find those?

Elizabeth Dalsey: Great question. In your binders, there is an IHS publication that talks about our initiative and provides those statistics. I also have copies on the table outside. Those statistics are from BLS.

Secretary Adam Geisler: BLS?

Elizabeth Dalsey: Bureau of Labor Statistics, excuse me. So that's included in there.

Secretary Adam Geisler: My- okay, well that was my second question, what was the source of information or how are you collecting this information. So it's coming through the Bureau of Labor.

Elizabeth Dalsey: Correct, it's coming from the Bureau of Labor, and with that data, we're not sure whether those fatalities are occurring on or off reservations so there's still – there's still a lot we don't know with that fatality data.

Secretary Adam Geisler: So they just know if they're Native. They don't know—okay.

Elizabeth Dalsey: Correct. We just know whether they've indicated Native or not.

Secretary Adam Geisler: Then my last question is you had mentioned that there's a grant available. What – what is the ceiling? How much is the total pot of money that's available?

Elizabeth Dalsey: I would have to look and get back to you. I know I saw that before but I don't want to misquote myself.

Secretary Adam Geisler: Okay, and then when will the NOFA come out? Is there an anticipated date?

Elizabeth Dalsey: It went up in – it went up last September, so it will be up for renewal again this September.

Secretary Adam Geisler: Thank you.

Elizabeth Dalsey: Thanks.

Councilman Chester Antone: Delia.

Tribal Council Member Delia Carlyle: Thank you, Mr. Chairman. I was just – you know, you mentioned dust control. I come from an agricultural setting and so when you mentioned dust control do you—and I’m sorry, I was trying to take down notes. Did you mention—because we have EPA working out there, too, also with dust control, you know, like work hazard-type situations, too. So do you work in conjunction with EPA, too?

Elizabeth Dalsey: We have worked with EPA in the past, and additionally, we have done some work with Ag workers and with youth, and I have some pamphlets outside that talk about some of the work that we have done. And we’re also looking to do more specifically with Valley Fever. So I could talk with you more about that and that’s another area we’d like to do more with as well.

Tribal Council Member Delia Carlyle: Okay, thank you.

Councilman Chester Antone: Any other questions, comments? Just one more on the data from tribes. Are they included in that state-based data systems or where do you obtain those?

Elizabeth Dalsey: Currently, we would still like to see how tribal data is included in some of the surveillance systems that are used for the state-based surveillance so it would be helpful, and one thing we’re trying to explore is what surveillance systems exist within the tribes. So that would be helpful and we’ll probably talk more about that later on with our initiative and with the workshop we’re planning is to really get a sense of what surveillance systems exist, what data systems exist within tribes to better capture worker data and information.

Councilman Chester Antone: Yeah, that’s very important because a lot of times states don’t have that data, and so I guess—yeah, that data that they don’t know or we don’t know where to send the data or they don’t know where to get our data and sometimes we don’t want to give our data and to keep it specifically into the tribe. But I was just wondering how that – how that would happen, and I guess it will be through the grant where you would discuss that and see what mechanisms you could come up with to collect data on workplace injury.

Elizabeth Dalsey: And the grants would go to the tribe and so they would be able to look at the data and determine how best to collect it and things of that nature.

Councilman Chester Antone: Okay, thank you.

Elizabeth Dalsey: Great. So I’m going to pass it on- was there another question?

Secretary Adam Geisler: I geek out on the data stuff because it's- we had a discussion this morning in our caucus about how we maintain the ability to be competitive for source of funds, and so it really is a point of interest for myself to understand the ins and outs of this but then also to look at the – at the parallel work that's going on with other federal agencies. And there is an effort underway currently to identify and understand through strategic highway safety plans, which is kind of misleading also because it doesn't just mean the highway itself, it means your- your interior and arterial roads within your community. And I found it interesting that you said that the number one cause was—did you say traffic related?

Elizabeth Dalsey: Transportation.

Secretary Adam Geisler: Transportation related. And so there's- there's already discussion going on on the transportation side about how they collect all this information because what we've – what we've learned over there is that everybody is collecting it differently. The locality has one system that they've financed and built, then you have the county that has it, then you have a tribe that has a way of doing it, and the state has their own thing and then they're all trying to upload it into some big federal system that doesn't talk to any of it. And so what I would suggest and that's being explored currently is a tribal-specific system that we can upload our information into. I think that's where it needs to go down the road, and from a – from a government-to-government standpoint, I personally think that that is how the data should be- being shared, directly with the—how do you say that? NIOSH. Directly with NIOSH or the CDC or HHS. It makes more sense. And obviously, it's to lead to our ability to make the argument that there should be direct funding to support this. But those are just my comments, Mr. Chairman.

Councilman Chester Antone: Thank you.

Constance Franklin: Good afternoon. We've already introduced me. I'm Constance Franklin with the National Institute for Occupational Safety & Health, and I'm here locally in the Atlanta office on the Century Center campus. And I want to just briefly introduce to you all the concept of Total Worker Health. Typically, when we think about health protection and health safety of our workers, it's very regulatory and all of these components that you see in this puzzle are usually operating separately. And when we think about health promotion, we think about changing behaviors, lifestyle interventions to an individual, again, separately. The Total Worker Health concept is an integration of health protection and health promotion, and instead of having—this picture shows all the pieces of the puzzle together and that is the goal of the Total Worker Health program is to have all these groups working together to promote health protection and health promotion, so we don't have the EAP or Employee Assistance Program folks operating separately from Demand and Disease Management people. We want everyone working together to promote health protection and health promotion. Some examples of effective interventions you can find right here on the campus of the CDC where, for example, we have efforts to talk about nutrition, healthy weight management, tackling obesity, diabetes, interventions like that. They have here, if you noticed in the cafeteria, all sorts of options available for food. There is a huge overhaul of the cafeteria, thankfully, and then they also have the garden markets that bring fresh

fruit and vegetables right here on campus where folks can go and buy healthy fruits and vegetables if that's not available in their community. So what can we do at work that will impact your home life and what is happening in your home that's impacting your work life? So we're looking at things from a total health perspective. Your mental health, your physical health, your safety at work and promoting healthy behaviors in both places. Any questions? That's a quick overview but any questions or thoughts about this concept of Total Worker Health? You may notice I have on my sneakers and I'm also wearing my Fit Bit. These are my own interventions to help myself. I knew I was gonna park in Egypt, so I thought I should wear the appropriate shoes, and I did plan to pack the more visually better-looking shoes but I forgot those, so I'm just rolling with it. So those are my own interventions, but we do have walking clubs here at all of our campuses and you may have noticed outside how pleasant things look with the fountains, things like that. So it's to encourage people to take a holistic approach, walk around, and get up from your desk, things like that. Really want to make it a better approach in the workplace, not just hammer down all the time, stay at your desk, do your work, and eat at your desk. No. Get up, walk around, and be healthy. We had Dr. Bauer present earlier and you all wouldn't know this but many of us will recall she sent an email, an email circulated around, about her practice not to send emails and read emails after a certain hour of the night. And we just brought this up in our office about having healthy approaches to your employees because if you're sending emails late at night and they're reading your emails late at night, they're feeling pressure to respond and do work and we don't want to, you know, do that unless it's an emergency. So we're really just trying to think how can we help people be safe and healthy on the job.

Councilman Chester Antone: Are there questions, comments?

Secretary Adam Geisler: As I shared with you before, I'll probably talk more than I should at these meetings but my question is do you have an example in Indian Country where this is – this is something that's going on or have you engaged with any tribes? Because I know businesses–there's different businesses that engage in this type of activity. For example, the Leukemia and Lymphoma Society has a large presence in San Diego, especially for the Rock N' Roll half Marathon and Full Marathon. And what I've noticed is that businesses will create a promotional plan or create a work schedule that works around the- the health benefits that are associated with training for an activity like that. But I haven't seen anything like that out in Indian Country and I guess I'm wondering if you've come across that or is there any way to support that through your program or a model of such?

Constance Franklin: Sure, and Liz actually said, ask that question. That's one of the questions we- we were gonna ask, and I was like, no, because I know we have 30 minutes left and she has some hands on native things that I'm sure you want to hear about, but that is one of our questions. How can we support tribes in efforts to promote health protection and health promotion? We are not aware of any interventions going on, but we, as an office, have some- we have funded some people – some universities that do work in their states so there may be an indirect intervention going on that we're not aware of. So that was one of the questions to ask you all if you are aware of any interventions or if you do have people assigned to worker safety and health

promotion in your tribes that could be working together to take a holistic approach at both protection and promotion, and how we can help with that. We're here to learn. Thank you.

Councilman Chester Antone: I think it was about five years ago that CDC—and I forget the – the center or the branch or whatever who came down to the—they didn't come down, we had a number of phone calls in- when we were having the CDC consultation at the Desert Diamond, down in Tucson and from that discussion, the main topic was allowing administrative leave for employees to walk, do things of that nature for their health, and they were allowed an hour. That's – that's what they were bringing to us, to- if we wanted to- some help to work on that. And so it took maybe 3-4 years without that CDC organization because we never touched base after that but we had informed the tribe about it. So the human resources office took over that so now we do have administrative leave for an hour for- for folks to walk and exercise.

Constance Franklin: That's amazing.

Councilman Chester Antone: So that's – that's what the nation has done for their employees, and, again, we looked at the insurance cost on health and you tie that with the safety of the drivers or patients that they haul or any vehicle within the nation, the insurance costs are pretty high. So looking at that and trying to get people to be more alert, I guess you will say, but they instituted that program and so far it's been going, I think, the last 2-3 years now.

Constance Franklin: That's really groundbreaking because we struggle with that as an agency, and we struggle with that as managers and supervisors, and the perception that your coworkers have if you're going for a walk and it's 10:00 a.m. and they're like, it's not lunchtime, if you're gonna exercise, you need to do that at lunch. Well, who says? You know, we have a culture that is often all different generations, all different ages and people have different perceptions of what folks do. So that's really groundbreaking that you were able to get a policy in place that allowed folks to walk without any strings attached. You have your hour you can exercise. We have facilities here and some people have flexible – you know, flexible arrangements where they're able to go any time and others do not. So that's a great message to send and a great opportunity for people to take advantage of when you have that flexibility and the culture is acceptable and they know kind of what the expectation or what that hour is for. It really makes a difference. It really does.

Joe Finkbonner: Glad to hear you guys also. Just want to give you—at our organization, Northwest Portland Area Indian Health Board, we have 30 minutes of wellness time that we give to our employees so that- and the only stipulation is that it can't be at the beginning of the day or the end of the day. It has to be used during the work hours, during the middle of the day. And in addition to that, we've also bought Varidesks, where you can lift them up and stand, and we also have three treadmill desks for general use so that people can sign up in two-hour blocks where they can get on a treadmill and walk at, you know, one or two miles an hour and work there if they've got- if they're not busy where they can just check emails or be on a conference call. I have a treadmill desk in my office, and it's surprising how quickly you become adapted to it, that before

I could barely type and walk and now I'm walking at about a mile and a half to two miles an hour and I'm typing and on phone conferences and people don't even know that I'm on a treadmill desk. And the other thing that- in terms of health promotion, that we do at the board is we allow a new parent to bring their child into the office for the first six months in order to encourage breastfeeding, and all of that is about that passive immunity that comes with breastfeeding and the nutrients that they'll get from that as well. So there are a lot of different things that we do. We even have a wellness committee that's the employees that try to think of different ways that we can promote wellness within the workplace because we believe that if you've got healthy, active, engaged employees, we're gonna retain them, we're gonna keep them healthy, we're gonna keep our insurance rates low, and by all means, it cleans their windshield, you know figuratively, that they're re-energized and ready to go back to work because they've worked off some of that energy that they've had just normally sitting behind a desk. And I do that because I've- reading articles that the sedentary lifestyle—and I call the desk the cigarette of the 21st century is that- that's gonna lead to our early demise more than all the other things, and all the articles I'm reading are saying that the 60 minutes that you spend in the gym three times a week doesn't erase the eight hours a day that you sit behind a desk, and you're better to be more active more incrementally throughout a day rather than just trying to do it all in like three or four times a week in the gym. So I've tried to promote that culture at our workplace and I encourage our employees to come up with new ideas about how we do that. We have a list serve now that people send out when they're doing their running—we have stairs near our office, they run stairs, they'll do run around the track down at the Y, they'll go down to the waterfront, the Eastbank Esplanade, which is like a five mile loop from the office, so- and then we also have people that are signing up to do various runs that are charitable runs like for the children's hospital and stuff, and then we've got a group, we've installed a shower in our workplace so that people can ride their bikes to work. We have at least six people that are full-time riders that ride their bikes to work every day and then now we have folks signing up for century rides, doing hundred mile bike rides. So all of that is just sort of steamrolling and more people looking for ways to become more active and making that a part of our culture at our office.

Constance Franklin: Thank you for sharing that. We call it sitting is the new smoking. We did not adopt that term but someone else has, and the time you spend commuting, as well as sitting at your desk, watching Scandal and eating dinner, does not balance out with your hour in the gym. NIOSH has about 1,100 employees across the country and we have distributed about 200 sit-stand work stations that you mentioned through a lottery process, and we also have the walking workstations and we have one in Atlanta. We have a small – small group of us here, about 50, and we have three in Cincinnati where there's about 300 employees, two in Morgantown, where we have about 300 employees, and one in our Morgantown office where there's about 300. So we are implementing that as well, so you're right, it sure does make a difference, and especially that I have this on my arm, I can tell when it's time to get up and walk around, I've been sitting too long, I can definitely tell I'm moving more. That's awesome. Thank you.

Councilman Chester Antone: Any other additional comments, questions?

Elizabeth Dalsey: Great, well thank you. We'll change gears a little bit and specifically focus now on young workers, workers younger than 24 years of age. Work has a positive impact on young people. Nearly 80% of youth work while they're in high school. Although they're working quite a bit and this does have an impact, young workers are injured on the job quite frequently and age 15-24 years of age are injured twice as likely as adults. Again, talking about young workers. And the injuries that young workers sustain have a lasting impression and impact on them such as chronic pain and decreased academic performance. So it's important that while youth are going to school and starting their first jobs that they get the basic skills that they need to be safe while they're on the job and that they can contribute to a safe and healthy and productive workplace. So to address that, NIOSH created a curriculum called Talking Safe. It teaches work readiness skills to middle school and high school students. It is- it's fun, it's free, it's interactive, and it's customized to each state. And the goal is to teach vital workplace safety and health skills and to integrate it within the school system. So the first – the initial curriculum was created and now they're being redone and being tailored now to specific audiences. So for instance, New York is being tailored to address students with disabilities. And so NIOSH is working now to tailor these curriculum to be more specific, and so with that, we're interested- NIOSH is interested- how or if there is a need for this curriculum within Indian Country and how we could tailor the curriculum and how it could be best promoted to native youth, so whether that's within the school systems, with youth development organizations, within community colleges or if there's training programs that we could best implement this training through. So that's one question we had for you guys. Additionally, we are further promoting the work safety curriculum and youth content through a partnership with "We R Native" to reach American Indian and Alaska Native youth. This was developed by the Northwest Portland Area Indian Health Board in 2011. This is an interactive website. It also includes text messaging services, a YouTube channel and various social media accounts. The goal of "We R Native" is to provide medically accurate, age appropriate health information on various health resources, physical, mental, social and spiritually health topics, and they were looking to expand and include information on worker safety and health. So we're providing content to them, and it will be reviewed and hopefully on their website soon. So this page is very well viewed and it's been very successful. They have over 160 page views annually and there are about 350 pages and the content is developed by subject matter experts and then it's reviewed by American Indian/Alaska Native youth, so it goes through a vigorous review process. So that's a little bit about young workers and the content NIOSH has and our partnership with "We R Native." So if anyone has questions regarding the NIOSH curriculum or how we're working with "We R Native", we can take some time here to address that.

Councilman Chester Antone: Cathy.

Tribal Board Member Cathy Abramson: Thank you, Mr. Chairman. I just wanted to get back and ask if CDC would approve the purchase of those stand-work stations through any grants or cooperative agreements. Is that- would that be something that we could do....approve purchasing of any of those walking desks, the sit-stand workstations through grants or cooperative agreements?

Constance Franklin: That's a very good question. That might be something that—I mean I would consider it an intervention, for sure. So we're not experts on the budget side though, the rules of those things. Definitely an intervention for sure.

Tribal Board Member Cathy Abramson: Well, it's something we must get on.

Lt. Governor Jefferson Keel: I guess my comment to that or my, I guess, observation would be that if it's something that would promote health or safety, and it's an initiative that the tribe is engaging in, that you ought to be able to – to include that as part of your grant. I don't know what the grant document looks like or how much is available. Can you talk about those?

Elizabeth Dalsey: That's a very good question. Currently, the only grant or funding we have available is through the state-based surveillance grant at this time. So at this moment, there isn't a grant mechanism, but that's something to explore and possibly discuss further because I think, as mentioned, it is an intervention so if there's a way to figure out a means to do that, it's worth exploring.

Lt. Governor Jefferson Keel: Well, the other question- the other part of that would be, you know, and we can talk to Joe about this, about, you know, the stations that you talk about, where those are available and how you can make those available because obviously you don't have to have approval to put those things in place. So we can talk about that off line. Thank you.

Elizabeth Dalsey: Thanks.

Councilman Chester Antone: I was gonna say the same thing because you can collect data off of those stations so that you could work that in your grant.

Elizabeth Dalsey: I'd like to follow up with Joe more because NIOSH has a Total Worker Health newsletter and it'd be great to highlight the work that Joe's done and, you know, promote that and, you know, and hopefully highlight that and get the word out more. So – and that could help, you know, spark interest as well.

Lt. Governor Jefferson Keel: Would OSHA require you wear safety glasses while you....?

(Laughter)

Elizabeth Dalsey: There is a safety protocol and appropriate shoes that must be worn when you're doing the—when you're using the workstation.

Lt. Governor Jefferson Keel: Steel-toed shoes, safety glasses, okay.

Constance Franklin: We do have some safety training that we require before folks are allowed to use it but goggles are not one, hard hat either.

Councilman Chester Antone: The other thing is you might follow the example of the diabetes education in tribal schools. That's come from here, right? CDC?

Elizabeth Dalsey: Thank you.

Councilman Chester Antone: Any other...? Geisler.

Secretary Adam Geisler: Thank you, Mr. Chairman. You had asked us a question regarding the Talking Safety curriculum development. Is that also part of the state? No?

Elizabeth Dalsey: No, it's not part of the state-based surveillance grant. It's a separate entity and all of the curriculum are currently available online. In your packets and additionally on the table outside, there is a one-pager that talks about the curriculum and all of the curriculum are available online. Currently they're being updated so they're being updated on a state-by-state basis.

Secretary Adam Geisler: So then to answer your question, personally I know my tribe would appreciate looking at a tribal-specific curriculum because there's- there's aspects to working in Indian Country that are – that are specific to Indian Country. For example, it's just good overall education when you start discussing TERO and aspects of the way that that works when you get into federal contracting and making sure that the youth, or employees in general, understand those nuances that are available to them as being citizens of a tribal nation. The other thing that I would suggest you reaching out is there's a—it's called NativeHire.org. It is a combination of Craig's List and Monsters.com mixed into one. It was created to bring federal contractors in compliance with TERO regulations with the Department of Labor. It was created right out of San Diego, California, which is why I'm talking about it because I helped create that. But it's a resource in which there's a lot of partners at the table where there is internships for youth and there's a number of different businesses that are participating where some of them are employing these activities that you're talking about but at the very least it would be a place to maybe house this tribal curriculum as it- as you roll it out, but they would also be a good partner in discussing the development of that curriculum because they have a good bearing on what's going on.

Elizabeth Dalsey: That's very helpful. Thank you. I will probably follow up with you after.

Secretary Adam Geisler: Great.

Councilman Chester Antone: Anything else?

Elizabeth Dalsey: Lastly, I wanted to discuss our American Indian/Alaska Native Initiative. We launched our new initiative back in 2013. Our director, John Howard, really wanted to put some focus on tribes and providing occupational safety and health. Since we launched our initiative here we have some activities that we have conducted since the initiative began. I've talked about

some of the baseline data we've obtained. I'm talking about the fatalities and we had an opportunity to visit Navajo OSHA with being on the Navajo Nation and that was a great experience and got to visit some of the enterprises that were out there. The IHS journal article that was published that's in your binders that talks about our plan and some of the data that I previously mentioned, and we've had an opportunity to present at tribal meetings such as this and at the National Indian Health Board. And we're really trying to develop partnerships and really learn what are the needs and priorities that exist and how we can best structure a program to meet those needs. So this really is a great opportunity to provide input and feedback as we develop our initiative as to what are those needs and how we can best provide support. We're very excited about the partnership workshop that we will be putting on in this summer or fall to enhance occupational safety and health capacity and really build partnerships and foster community around workplace safety and health. We're really- and the objectives are listed here so I won't read those off but a lot of the things that I have mentioned about identifying priorities within tribal communities and developing partnerships to figure out how best we can meet those needs and really identifying data sources and surveillance systems that exist so we can start collecting some of the data. We are in the process of putting an agenda together and we are hoping through discussion, and I think we've got some of those topics already identified, but if this group has ideas for content that they would be interested in hearing more about, about building capacity, about data sources, about what are these new and current issues that are occurring on tribal land, whether it's, you know, oil and gas issues or possibly Valley Fever or other new things that are occurring. So if people have ideas for topics for our partnership workshop, or the goal is really to bring together those that are responsible for workplace safety and health that are currently dealing with it. Constance asked the question are there representatives or who are the individuals that are responsible for workplace safety and health within the tribes, if there's ideas for who those people are, we welcome those individuals. So if people have ideas or thoughts, you know, we welcome those or additional input on what could be driving our initiative that would be helpful as well. So I'll sort of open it up to additional thoughts or thoughts that individuals had throughout our presentation.

Councilman Chester Antone: Are there any comments, suggestions? Ramona?

Ramona Antone-Nez: This is Ramona from Navajo Nation. So one of the things that I see that we can work towards or suggest is occupational epidemiology to identify the risk and protective factors as it's related to work and- work injury and also possibly mortality. One of the things that I'm understanding you spoke about is the prevalence rates of the health disparity that American Indian/Alaska Natives may face as it's work related. You mentioned the 21 indicators and I'm looking for that in here and don't see where that—what exactly you're studying or investigating. I would be interested in that. And I just wanted to acknowledge your PowerPoint that you did visit the Navajo Nation OSHA and there is a great need, at least at Navajo, to identify—not only identify but to collect data. We talked about the data – the need for database and the need to identify how it relates to Worker's Comp and the cost of work lost to a person who is injured. So there is a lot of potential for epidemiology to become more involved and so I just want to give a shout out to the epi centers that this may be another place where specifically the workforce that

is behind the nation, your tribe, your community that actually implements these different services that we're providing to the people who we serve. So it's important that we keep our employees injured-free and get them home safely. I mentioned that a couple of times when OSHA came to visit us. So thank you, those are my comments.

Elizabeth Dalsey: Thank you.

Councilman Chester Antone: Any other comments?

Virginia Hedrick: Hi, Virginia Hedrick, Program Manager at the California Rural Indian Health Board. We're just sharing that for many tribes and tribal areas, tribes are the largest employer, particularly in California and really small reservations and Rancherias, the tribes employ almost everyone in the area, both Indian and non-Indian people, and many tribes have very high populations of tribal employees. So when we think about how we can improve worker safety and health, we have a really great opportunity to improve the health of the community as a whole, as this being one avenue where everyone is going there for employment and so I appreciate looking in Indian Country and how we can improve employer conditions and would welcome—we were talking about sharing best practices. I know the Northwest Portland Area Indian Health Board really has been a leader in this and at the California Rural Indian Health Board, we have looked to them and borrowed policies on breastfeeding in the workplace and allowing that 30 minutes of wellness in the workplace. So there are places where this is really working and that's at an area health board but when you look at tribes in much smaller areas, are these practices making it to them? Are we sharing this knowledge of how do we improve worker health, I'm not so sure that it's happening there. I am a member of the Yurok tribe and in that area particularly we have a really- a very high number of tribal employees working in fisheries and in forestry and in those neighboring reservations. That's where a lot of our young men are working and we know that accidents happen a lot in younger Indian men in those workforces, so I appreciate you all coming and then would welcome a best practices webinar or onsite trainings.

Elizabeth Dalsey: Thank you.

Councilman Chester Antone: Thank you. Cathy?

Tribal Board Member Cathy Abramson: Our Inter-Tribal Council of Michigan adopted that breastfeeding at the work – workplace, and my daughter, not only that was helpful and healthy for her baby, but my granddaughter, she is now nine years old, and she went to work with her mother and so she could be breastfed and the thing that calmed her down when I watched her, and that is to bring her over to the computer and she just relaxed and she loved the computer and she still loves the computer and she is doing super in math. It's really – it's interesting.

Elizabeth Dalsey: Thank you.

Councilman Chester Antone: Anything else?

Elizabeth Dalsey: No, that's all. I really appreciate the time and thank you for everyone's feedback, and we're here the rest of today and tomorrow. Thank you.

CDC Tribal Motor Vehicle Injury Prevention Program & CDC's Efforts in Suicide Prevention

Councilman Chester Antone: Okay, thank you. Now we will move on to the CDC Tribal Motor Vehicle Injury Prevention Program and CDC's Efforts in Suicide Prevention, and this will be by Captain Holly Billie, MPH, RS Navajo; CDR Alex E. Crosby, MD, MPH; and LCDR Asha Ivey-Stephenson, Ph.D.

CAPT Holly Billie: Good afternoon, everyone. I think with that introduction, you're going to really believe that the Navajos are everywhere. As was introduced, I'm Holly Billie. I'm Navajo from Montezuma Creek, Utah, and I serve here at CDC's Injury Center as their Injury Prevention Specialist, and I mostly work with tribes. And I'm here to give an update on the Tribal Motor Vehicle Injury Prevention Program, otherwise known as TMVIPP, so when you hear me say TMVIPP, that- that is less of a mouthful than Tribal Motor Vehicle Injury Prevention Program. I'd like to start by giving just a quick overview of the magnitude of the problem in Indian Country for motor vehicle injuries. I'll talk a little bit about some details about TMVIPP and also federal partnerships, how we are working with other federal agencies, specifically on this topic of motor vehicle injuries. There are three projects that I'd like to specifically focus on although we have other projects going. But there are three specific TAC concerns that I wanted to put up on the screen that have been brought up in previous meetings that I think that the Injury Center is, you know, working to address and those specifically are direct funding to tribes, which you'll hear me talking about; reporting on tribal programs in various ways and this being one of them; and then working with other federal agencies to- to benefit Indian Country. Alright, this is just a reminder how big is the problem for American Indians and Alaska Natives. Unintentional injuries are still the leading cause of death for those ages 1 to 44, and motor vehicles crashes are the leading injury type. So there's still a lot of work to be done. This slide shows unintentional injury deaths for ages 1 to 44 by race, and you'll see that—actually you won't see that American Indians and Alaska Natives—I'm not sure what happened to this slide but the American Indian/Alaska Native rate is 32.2 versus what you see up there on the screen. And the 32.2 is actually a 2013 update. What we have on this slide is 2012, and Dr. Crosby will let you- probably let you know that the database that we use for injuries, WISQARS, has been updated since these slides were turned in. But American Indians/Alaska Natives have higher rates than other- other races for unintentional injury deaths. Now, if you were to look at that – if you were look at just American Indians and Alaska Natives in that age group for unintentional injury deaths, you would see that nearly half of those deaths are caused by motor vehicle traffic, and then about a third from poisoning. And this is poisoning from prescription drug overdose, alcohol and narcotics. And then drowning and other types of unintentional injuries make up the rest of those 5,000 or so unintentional injury deaths. So that's just a reminder that motor vehicle crashes are still a huge problem in Indian

Country. This is a map of the states of—well, this shows motor vehicle injury death rates just for tribes- American Indian/Alaska Natives in the states, and the darker the blue, the higher the rate. And what I did was I put the actual rate number on the states with the highest rates of death for AIAN. Now, in response to that, CDC Injury Center developed TMVIPP and the purpose of TMVIPP was really to tailor and implement and evaluate interventions in tribal communities and at the same time, learn, you know, what facilitates these programs and what barriers are there in implementing these in tribal communities. There was a cooperative agreement that was implemented from 2004 to 2009. I've given updates on the- on that particular group of tribes that were funded in previous TAC meetings so I'm not going to go into details. But the tribes that you see up on the screen are the tribes that were funded in that first round of funding and they had really good results. And from 2010 to 2014, an additional eight tribes were funded. Again, they were asked to select at least two evidence-based strategies of the three that I'm going to mention, which is reducing alcohol impaired driving, increasing child safety seat use, and also increasing seatbelt use. They also- basically the design was to hire a full-time coordinator who would then go in and coordinate these activities that included giving out child safety seats, working with law enforcement, and also doing media campaigns to educate the community about traffic safety laws. They also did some partnership building, collected data, and then did restraint use observations. So they had their hands full. This slide shows the tribes that were funded. You have Caddo, CRIHB- California Rural Indian Health Board, Colorado River Indian Tribes, Hopi, Oglala Sioux, Rosebud Sioux, Sisseton Wahpeton Oyate, and SEARHC- Southeast Alaska Regional Health Consortium. And you can see that Caddo and Rosebud all selected to implement all three strategies. Now, what I'm going to do in this next little section is just pull out some very brief highlights of each- of each program. Each coordinator did a lot of work in this area and they actually recorded a webinar that I'll let you know about at the end. But for Caddo Nation, the coordinator was Toni Short. She did an excellent job at forming partnerships with police departments, BIA, Oklahoma Highway Patrol, and Anadarko. And it's a little bit tough to see on the slide but the purple – the purple bar is the Caddo Nation Child Safety Seat Use Rate, and you can see that there was an uptick during the program years. The other two bars, the orange and the peach, the orange is the Oklahoma rate and the other is the national rate. That was good to see. And then for California Rural Indian Health Board, they were funded on behalf of the Yurok Tribe. Their coordinator was Danielle Lippert. There's a lot of information on that slide but what I wanted to pull out is the red bar, which shows child safety seat use for Yurok Tribe, which improved from 53% use to about 71% use. What was great about the Yurok Tribe, Danielle worked with the police department. They were able to pass traffic ordinance in 2012 that included a seatbelt – a seatbelt law and also a child safety seat law, and a .04 BAC limit, which is actually stronger than the .08 limit for the state of California. So they also developed a fee diversion program for tribal members who were- who were cited for not using a car seat. Then there's Colorado River Indian Tribes. Their coordinator was Hannah Ward-Harper. She did an excellent job with working with enforcement, and also her passion and her – her talent really lay in media and getting the word out to tribal members and there's, again, a lot of information on this – on this chart but if you would notice the purple line, the purple line denotes motor vehicle crashes with injuries and they saw a decrease during this project year. Hopi Tribe's coordinator was Greg Sehongva. He was very instrumental in getting a safety seat program

started for Hopi. You will see that the red bar shows an increase in child safety seat use for that community as well as a downward trend for motor vehicle crashes with injuries, which is the purple line. There's Oglala Sioux Tribe. Their coordinator was Connie Johnson. This particular tribe did a really good job in coordinating their activities with other tribal departments that were funded for basically the same thing. So Connie worked with the person who was hired to work with the BIA police department through BIA funding and also Indian Health Service, who funded someone to work with car seats. So Connie worked with them very well and they can collectively share the successes of this program as a result. You will see that they also have a downward trend for their crashes with injuries and an increase in their seatbelt use, which is the blue bar. Rosebud Sioux Tribe, their coordinator was Richard Braca. He worked really well with the schools and also led the local coalition. You can see that Rosebud started very low with seatbelt use, only 9% at the time that the program started, and they finished out the project at 26%, which is much lower than the green bar which denotes South Dakota and also the blue, which denotes national, but it was still an increase and they were very happy to see that, as were we. Sisseton-Wahpeton Oyate, their coordinator was Shannon White. She worked well with the police department at enforcement events. Their seatbelt use stayed relatively the same, but they were able to increase their DUI arrests over the – over the program period. Southeast Alaska Regional Health Consortium, their coordinator was Lesa Way, and there you can also see an improvement in child safety seat use, denoted in red. But I think that her big accomplishment that she wanted to share with everyone is a 23% increase in high school seatbelt use. She worked with the two local high schools in Juno and had great success. There were quite a few lessons learned during this project, both for CDC and for the tribal partners. Through the cooperative agreement, there was extensive technical assistance that was needed not only by- provided by CDC but also with the specific contract by the University Of North Carolina School Of Public Health. They worked with each tribe individually with – with the requirements of the program. We also had a partnership with Indian Health Service which provided on-the-ground technical assistance through the Office of Environmental Health and Engineering. A full-time coordinator was key to this program. Really, someone needed to be working their full time on the topic. The partnerships that they developed were absolutely critical, and there is a short list there of- of the programs that really – really needed to be involved. One challenge was the level of public health experience by the coordinators that were hired. Of course, the tribes will hire the folks that- that they feel are the best in their community, and their level of public health experience really varied from none to, you know, higher in public health professionals. And so the – the technical assistance needed to be tailored as well. Tribal infrastructure was also key and turnover was a big challenge in several portions of the program, both in the coordinator positions and also in the support programs at the tribe, whether it was in the grant's office or whether it was in the, you know, the chief of police. Turnover was a big challenge throughout the- the program. So those were a few lessons learned, and as I mentioned, the tribes came here to CDC, the coordinators came to CDC last summer and presented their work in their own words and they highlighted what they wanted to highlight, and they also did a webinar that was a national webinar. It was recorded and it now lives on safestates.org, so I would recommend that you invite the folks that you know to check it out and because the recording is there and the PowerPoint slides are there as well, and you'll hear in their own words the good work that they did. We also have additional information on the

Native American Road Safety web page at CDC, and we only have three tribes that have agreed to- for us to share their information. We asked every tribe, you guys did a really great job, can we, you know, put your results out there, and only Rosebud, Yurok Tribe and Hopi agreed for us to share their information. So you'll see that information soon on the web page. Are there any questions up to this point specifically about the Tribal Motor Vehicle Injury Prevention Program before I move on?

Councilman Chester Antone: Ramona?

Ramona Antone-Nez: Thank you. This is Ramona from Navajo Nation. Thank you for your presentations, Ms. Billie. I just wanted to clarify that the cooperative agreements have now ended. The first cohort was to 2009 and the second one ended 2014.

CAPT Holly Billie: Yes.

Ramona Antone-Nez: And therefore this cooperative agreement is- is now ended. Is there plans to have another round of cooperative agreement awards based upon the success in decline of these specific tribes that had participated in this cooperative agreement?

CAPT Holly Billie: Well, we are exploring other ways to work with the tribes and right now, we're planning for not this coming fiscal year but the following fiscal year and that is on the table for discussion is – is the possibility of continuing that particular program or something very similar. So at this point, we are talking about it and making decisions about it, and I really hope that the decision is made to continue the program because it got some really good results.

Ramona Antone-Nez: Yeah, I also want to ask about—well, first of all the comment that I have is Navajo Nation has identified that the leading cause of mortality is unintentional injuries, not only for motor vehicle but also pedestrians that are walking alongside of the road, and I'm curious if the tribes had identified those types of collection of information, like what is- what was their indicators from their baseline to how they made their improvements over time. I'm really interested in that. Thank you.

CAPT Holly Billie: Well, for- for any kind of data that was collected, it really varied from tribe to tribe, and the tribe that looked at pedestrians specifically was Sisseton-Wahpeton Oyate, and even though they looked at pedestrian injuries, they weren't confident in the quality of the data that was collected, but they did see some data that indicated that pedestrian injuries were a problem. Did I answer your question? Okay.

Secretary Adam Geisler: Good afternoon. Thank you for the presentation. My question is centered around the source of data that you referenced in the map for 2004 to 2010, you know, showing the number of—is it the death rates?

CAPT Holly Billie: Yes, motor vehicle death rates.

Secretary Adam Geisler: So are you pulling that out of FARS?

Holly: We are pulling that out of WISQARS, which is the CDC—you're familiar with WISQARS?

Secretary Adam Geisler: Yes.

CAPT Holly Billie: Yes, that is the injury database that we use and that was pulled out of WISQARS.

Secretary Adam Geisler: Okay. How are you- it's kind of along the same lines. My reservation was awarded \$4.1 million this year through the Active Transportation Program through conducting walk audits and looking at doing—we conducted an active transportation assessment in working with the California Department of Public Health as well as Caltrans and BIA DOT in looking at our highway safety assessment or safety audit. We shy away from the word audit so we use the word assessment. I think it just makes our community members feel better. But my- my question is, and I just found this out through my local clinic two weeks ago that they have been collecting data for over ten years on- it's exact same program. It's- they hand out child safety seats or I'm sorry I don't know the technical term what you call that, but child safety seats. They're monitoring people that are wearing seatbelts in the community and what was interesting to me was that I'd been doing transportation for the last four years, I had never heard of—I mean, I guess I was aware but I didn't realize that it was there. So how- how is the information being shared or- or do you see areas where we can improve on sharing the information amongst tribes is my first question. And then my second question is did- for these specific tribes that were funded, where did they house this? Was it something that was handled under the tribe's transportation department, like I know Yurok has an amazing transportation department, or was it something handled under their clinic?

CAPT Holly Billie: I'll answer your second question first. The answer to the second question about where- where were these positions housed, it really varied. When the tribes applied for the funding, they told us where would be the best fit, and sometimes it was in the police department, and sometimes it was within community health, and sometimes it was a separate office in the- in the tribe—I guess it would've been community health as well. And so but I would say that about half of them were with the police department because they worked with the police department really closely. Most of their activities were enforcement related. And then your other question about how tribes can better communicate, we've had the same discussion with the partners that I meet with on a quarterly basis. I meet – actually- it's actually the next slide. I meet on a regular basis with IHS, BIA, Indian Highway Safety, National Highway Traffic Safety Administration- (NHTSA), and FHWA- Federal Highway. We also talk about how can we best communicate not only the resources but what is available to tribes, and I think that the way that tribes can better communicate with each other is by first starting within their own tribe between like programs. You mentioned Department of Transportation at Yurok, for instance. Yurok- Yurok, their Department of Transportation had regular contact with this coordinator that I mentioned, Danielle Lippert, and then they also had regular contact with the police department. So they

were- they improved, you know, communication on highway safety but I think that a lot of tribes, that is one way that they can improve is just communicate with- amongst their programs to see what like programs are available and then think about helping each other or to see where, you know, they might fit in highway safety. So that's one possible way.

Secretary Adam Geisler: Are you seeing any challenges in terms of tribes' ability to get you the information that- that you need?

CAPT Holly Billie: The data?

Secretary Adam Geisler: Yeah.

CAPT Holly Billie: Absolutely. That was – that was another really big challenge. The- the data that I presented today from each – from each tribe, that's the information that they collected and the- the confidence that they had in their data really varied from site to site. And that – that was a challenge and also the Injury Center recognizes that and so we partnered with Indian Health Service and we actually developed a course on how to put together a surveillance system to collect injury data, and right- the project is basically complete and it's going through clearance and we're hoping for a release of that course by the end of this calendar year. So basically it's – it's a tool that will hopefully help tribes to develop their tailored or their tribe-specific data collection for injuries. So we hope to get that out there at the end of the calendar year.

Ramona Antone-Nez: Thank you. For your effective strategies that are five nations that had selected the impaired driving prevention. I am interested and I'd like to ask if it's possible to get a copy or a- a highlight about how these nations addressed specifically impaired driving prevention. And is that- you mentioned their confidence in their data varied, but I'd be very interested in strategies that they found effective and therefore become evidence-based and how that might be able to be used across Indian Country. It seems- a side comment is that it seems like that would be very challenging; however, I'd be interested in how nations have addressed that particular strategy.

CAPT Holly Billie: So your question was, you know, will we be able to share the successes, especially related to alcohol impaired driving with other tribes, and the answer is absolutely. And if I – I'll go ahead and if I can continue with my presentation, I think that it'll answer your question, if that's okay. Alright. So as I mentioned, these are our federal partners that- that I meet with on a regular basis to talk about highway safety, and one of the projects that we're working on right now is a Modified Safety Circuit Rider Project and it's a pilot and a safety circuit rider really is a person who goes from tribe to tribe providing technical assistance. Well, in the past, they've provided technical assistance only on engineering, which is improving roads and bridges. But we're working with them so that we can put an FTE there to provide technical assistance in addition to engineering and those are the behavioral approaches, as I mentioned, car seat, seatbelts, and DUI prevention. We're going to- we have placed these positions at three out of the seven tribal technical assistance program centers that are run by Federal Highway. And the

partners that we'll be working with are Western, Southern Plains, and Northern Plains. Collectively, these three regional offices serve 207 tribes in ten states. So that is one way that we're trying to expand our reach to tribes with this best practice. Another more recent collaboration is with IHS. We've developed a toolkit on restraint use and DUI prevention. We've developed fact sheets, posters, and brochures that will be released soon. We also developed a video and that went out in 2014. It's available on our website, and if we have time, I can go ahead and play this short video. It's a four-minute video that any tribe can use that just gives basic- basic messaging for buckling up and not drinking and driving. Again, this is available on the CDC website but it'll also be distributed by IHS.

Video – “A Killer in Indian Country” – available at <https://youtu.be/yF7XLIjf7L8>

CAPT Holly Billie: Are there any questions about that video or that toolkit campaign? Again, this can be found on the Native American Road Safety web page and Indian Health Service is planning on putting them on DVD and shipping them out upon request and also making it available on their website as well.

Councilman Chester Antone: Cathy?

Tribal Board Member Cathy Abramson: I just wanted to go back and ask if there was any data that breaks down injury mortality by contributing factors. And do you have any...

CAPT Holly Billie: I'm sorry, can you repeat your question?

Tribal Board Member Cathy Abramson: Are there any data that breaks down injury mortality by contributing factors and would you have any sample database?

CAPT Holly Billie: The contributing factors, we do have data, some data about what contributes to crashes, and they are very closely tied with the effective strategies that I've been talking about, and that is low use of seatbelts, low use of child safety seat use – low use of child safety seats, and also incorrect use of child safety seats. Even when parents do use them, sometimes they're used incorrectly. And then drinking while impaired. Those are the big contributing factors to crashes. Alright. Alright, I can't seem to forward this slide. Is that something you can do up there? Thank you. Alright, this last project that I'll mention is a joint project between CDC, IHS, and BIA, and this is a best practice manual that we're putting together so it – it speaks – or it answers Ramona's questions about whether or not we'll share this information. But the best practice manual will be a guide for tribes, and it'll highlight successful tribal programs and it'll be filled with lessons learned from the tribes as well as the program, and it'll also have case studies. And these will come from tribes that have been funded by CDC, IHS, and BIA. And we are actively working on this right now and we hope—I'm almost afraid to give it a date, but hopefully, at the end of the calendar year or early next year is when we'll hope to get it out there. Are there any other questions about Tribal Motor Vehicle Injury Prevention?

Councilman Chester Antone: Go on.

CAPT Holly Billie: Alright, well, thank you for your time and I'll turn it over to Dr. Crosby.

CDR Alex E. Crosby: Good afternoon to all of you. My name is Alex Crosby. I work over in the Surveillance Branch in the Division of Violence Prevention, and I'm also accompanied this morning by Lieutenant Commander Asha Ivey-Stephenson, who also does some of our work in surveillance and especially focusing on suicidal behavior and the prevention of suicidal behavior. So I'll talk a little bit about some of our efforts there and going on in regards to the trends, which populations are at greatest risk, if we know something about males or females, or about adolescents versus young adults versus older populations, we can describe that there. The next thing we try to do is identify what are some of the causes; looking at the risk factors, looking at the protective factors, try to explain and understand why a- a pattern is exhibited and what's going on in that regard. Then next, we look in the blue, which it says develop and evaluate the programs and the policies. If we know something about the why; why this particular issue occurs more commonly in a particular population, we ought to be able to then design the programs or the policies, or the practices that help influence that in figuring out what works and what doesn't, and then we can move to that last one in the yellow- implementation and dissemination. Oftentimes these four, as I've kind of depicted it a little bit as a cycle, are going on at the same time, so we're doing all four of those things to try to figure out what's best in regards to describing the problem and then trying to intervene or prevent it. This shows a little bit of the- the pattern in terms of leading causes of death by ethnicity, and as Holly mentioned, that one of the things that we just recently updated on our website is the 2013 mortality data. One of the things here is just to highlight where suicide ranks in terms of the leading cause of death among different populations within the United States. Overall, in the United States, suicide is the 10th leading cause of death. In 2013, there were over 40,000 deaths due to suicide across the United States. You can see right in the middle there, American Indians and Alaska Natives, that suicide was the 8th leading cause of death, so it ranks among the top ten within that population also. When you look specifically at American Indian and Alaska Native populations in 2013, you can see that two of the things that we deal with, in regards to the Division of Violence Prevention, homicide and suicide rank among the top five. When you look especially at children starting at age 10 going up to those in middle age and 40 to 49, you see among those who are 10 to 19 years of age, suicide the second leading cause of death, homicide the third. In those who are in their 20's, suicide the second leading cause of death; moving to those in their 30's, the third leading cause of death; and then those in their 40's, the fifth leading cause of death, so it definitely disproportionately affects young people, especially adolescents and young adults, as the leading cause of death. This slide has several different things going on here, but one of the things that you see if you focus on- and I guess I am pointing at this, which you are not going to see- if you look at this line here, in terms of that in the black that among American Indians and Alaska Natives, you can see that really where the problem is, in regards to suicidal behavior is among adolescents and young adults, especially those age 15 into about their 30's, that's where the highest rates are in the United States, in regards to looking at a specific racial and ethnic population. This data is combined over several different years, but you can see there are different patterns here so as we

are looking at describing what the patterns are, and you're thinking about where your prevention program might focus, if you're trying to prevent deaths due to suicide among American Indians/Alaska Natives, you might focus on that adolescent and young adult population, whereas maybe if you were looking at white non-Hispanics, it's the middle aged population where you see the highest suicide; so just to help in terms of looking at the patterns to help you direct where your prevention program might go. This is some of the data from Alaska, and I know that was a specific question from the advisory committee about violent deaths among Alaska Natives. And just to highlight here, as we are talking about some of the patterns, one of the things that we've been doing recently is we funded the National Violent Death Reporting System, which covers currently, has just been expanded to thirty-two states. One of the states that actually has some of the best collaboration between our violent death reporting system folks, the folks that work in the State Injury Program along with those in the Tribal Epidemiology Centers, actually are Alaska program and so they have worked with some of the folks in regards to death certificate data looking at some of the other information that's available to try to describe what are some of the patterns and then help move that towards prevention. Here you can see that among Alaskan, especially the males, they have the highest rates of violent deaths; and those tend to be violent deaths due to homicide and suicide and so you can see there on the very top line that the males tend to have the very highest rates, the females down a little bit lower; but definitely higher than non-native populations in Alaska. This is one of the Atlases that they have put together that describe those violent injuries in which they've given some of the description of the patterns, what's been going on in terms of trends, what's been happening in terms of increases and decreases, one of the things that they've highlighted is between 1992 and '95, compared to 2008 and 2009, there was a decrease in the rates of death due to homicide and among suicide, so there was some positive news in terms of homicides and suicides coming down in those populations. The violent death rates among Alaska Natives by age group, and here just to demonstrate, the same kind of pattern that I mentioned before; highest rates among those who are adolescents and young adults and then rates start to drop as you move into middle-aged and older populations. Looks like we went backwards. Let me talk a little bit about some of the activities that we have been doing in- in collaboration with several other agencies. There're multiple activities that we've got along with some of the collaborations. The first one's that's listed there is the Garrett Lee Smith Memorial Act, and that's one in which we have worked with SAMHSA, Substance Abuse and Mental Health Services Administration. Garrett Lee Smith, just to kind of give you a little bit of the background of the story, was the son of Senator Gordon Smith, former senator from Oregon who died as a result of suicide while he was a college student. He was able to introduce a bill, and get it appropriated, that funded youth suicide prevention around the country. Currently, what that program funds, is around 30-some states to do youth suicide prevention and about a handful of tribes, I think it's somewhere between five to ten tribes, to do specific youth suicide prevention. We have worked with that particular group to help do more rigorous evaluation of those programs to try and see whether those programs are really working; describe some of the characteristics of those programs, and also take some of the principles of those programs and spread it to some of the other groups. The three that we initially funded, one of which was the Native American Rehabilitation Association in Oregon that works with I think it was eight or nine federally recognized tribes in Oregon. We helped them in terms of doing

the evaluation, they also helped develop a tool, in terms of a measurement tool, for trying to look at survey information among youth about risk as well as protective factors and this was one of the unique aspects of that survey tool. Many of the tools that we have that look at issues regarding health outcomes, you know, whether you're talking about alcohol use, substance use, suicidal behavior, interpersonal violence, have focused just on risk factors. This one included protective factors that asked the youth about different kinds of participation in their own cultural activities and were able to find that there were several things that were protective for those youth, and so this was a tool that we also took and, you know, advertised to other tribes to say that they might have to develop different kinds of questions, but there are ways of looking at some of the protective factors. The Tribal Epidemiology Centers, many of these are funded by the Indian Health Service; this group helps provide some additional scientific support for different tribes that are doing programs in regards to various kinds of health outcomes. We have worked with several of them that are doing work in regards to suicides, some that are doing work in regards to motor vehicle, and others that have been funded through the Indian Health Service. There was a specific program that looked at methamphetamines in suicide and so that group, along with us, have provided some technical assistance to several tribes in regards to the suicide aspect. The next one there, the National Action Alliance for Suicide Prevention, is a group that does oversight of the United States National Suicide Prevention Strategy and within that group there's a task force that focuses on American Indian and Alaska Native suicide prevention. We have worked with that group, in addition, the Data and Surveillance Task Force, which is what the Division of Violence Prevention focuses on to help develop some of the activities for that group and to help release a report that focuses on how we can better improve data for American Indians and Alaska Natives and then also moving towards prevention. And then the last one, the National Violent Death Reporting System, and I'll say just a little bit more about that. These are some of the little bit more of the detail about some of those different programs in regards to whether we're providing technical assistance, whether we're focusing on a particular age group in regards to what those programs are, and then I'll move on and talk a little bit more about the Violent Death Reporting System. This was a system that began back in 2002. One of the things that had been identified in regards to looking at suicides, and describing suicides, is that many states and many tribes had to use death certificate data to try to describe what was going on in regards to suicides. Death certificate data, in case you didn't know, pretty much has what I call name, rank, serial number, and that's about it. You know, it will tell you male versus female, it'll tell you an age; it'll tell you what the cause of death was, but won't describe the circumstances at all and if you're really trying to develop a prevention activity, you might need to know about whether the person had a past medical history; or what the person's past psychiatric history, or did they have a history of substance abuse, or did you know about a job problem, or a relationship problem, or a school crisis; or something that occurred within the past two weeks, in particular, that might help you determine where your prevention program might focus on to try to prevent those kind of deaths. So what the Violent Death Reporting System does is it tries to get at that kind of information. One of the ways it does that, and that its primary way of doing that, is it combines several different data systems together, so it includes information from death certificate data, but it also goes to the medical examiner and coroner and adds their information, including narrative information and also includes law enforcement information. Those are the

three primary sources, but in many states, they also include toxicology information so you might know whether that person or the decedent, you know, was there alcohol involved? Was the person, you know, above the legal alcohol limit? Were there other substances that might have been involved in that? Many of the- the groups that use this information also add in other kinds of information like in some states and in some areas, they have a Child Fatality Review Committee that includes information about children that die of unnatural deaths before the age of 18 in which they bring together social service, and education, and law enforcement; that's added into that data, too. You can see the most recent expansion of that. Just last year, we got money to expand that system from 18 states up to 32 states, and you can see what that looks like in terms of now we will be expanding to cover most of the United States in regards to what that system is able to collect. We have realized as we have looked at some of the issues regarding violence, and especially homicides and suicides, that health inequities exist for many of those different violent occurrences and especially for some populations, American Indian and Alaska Native populations; but others too, that they are big problem and we are trying to address what are some of the unique of risk factors, what are some of the ways to address them, but not just the risk factors, but also some of the unique prevention programs that might be focused on those populations. I can see that, you know, all of the wording here is very off in regards to what's going on here. We know that violent outcomes are influenced by a number of different factors. When you look at suicidal behavior, when you look at interpersonal violence and homicide, it's not just one thing that puts a person at risk for suicide. What we've found is that you can look at things at the individual level. You can look at things at the peer level and the family level. You can also look within the community and there are factors within the community and then also at the societal level and the broader community; what are things that are going on? All of those factors can play a role in any one individual engaging in suicidal behavior. Public health has a valuable role in addressing these problems. Often times when communities think about problems, especially homicide, they often times think law enforcement is the only way to go; but we have found that really because these are societal problems, homicide as well as suicide, that really you've got to look at a multi-sectorial type of activity. You've got to look how schools can work with law enforcement, can work with social service, can work with the clinical care community, can work with public health in order to really address a problem from a comprehensive matter that we've found in communities that do that, that they are much more successful. And then, research has shown that much of suicidal behavior can be prevented. It's hard to read there down at the bottom, but for many people in- in the public, they don't believe that you can do anything about suicide. You know, mental health in and of itself, because that is a big component of suicide, many people thought that you know, you can't do anything about it. Once some person has made up their mind that they want to engage in suicidal behavior, there's no way to stop them. But actually, suicide researchers have shown, that the majority of people, almost all, are ambivalent. They can't come up with another alternative, but when you present them with that alternative, many folks will take that way out. And, you know, one example of this, in which they were able to demonstrate this very well, was the Air Force had a youth suicide prevention program in which once they implemented that program they saw a drop of 70% in regards to suicides that occurred among their active duty personnel. Just to demonstrate that when you really do a kind of program that has a multi-faceted component to it, and a comprehensive nature

to it, that you really can make a big difference in regards to suicidal behavior. So I will stop right there and then you see I got extra slides, we're not going to go into those right now. But if you have any questions, you can definitely ask and I'll try to answer regarding, or- or Dr. Stephenson, regarding some of the things that we're doing in regards to suicide prevention; or other things that we might be doing in- in the Division of Violence Prevention.

Councilman Chester Antone: Are there any questions? Comments?

CDR Alex E. Crosby: That means it was perfect, right?

Councilman Chester Antone: You explained everything. Ramona?

Ramona Antone-Nez: Thank you for your presentation. I- your last bullet on the research has shown much of how suicidal behavioral- behavior can be prevented. I would like to ask if you would be willing to share one or two articles on that. Perhaps you have that in your archive? Just so that we could immediately see where this research is coming and how it's saying it was recommendations, etc.; because I really like that you present—when options are presented, then that's one method to prevent suicide. Thank you.

CDR Alex E. Crosby: Absolutely, absolutely, we can share that with you. There are definitely a couple of specific suicide prevention programs that were implemented and evaluated that were among American Indian populations. Initially, it was called The Natural Helpers Program; another one called The Life Skills Program, and both of those actually have been entered into there is a- what's called The National Registry of Evidence Based Programs and Policies and both of those two programs are in there. The Natural Helpers Program, just to give you kind of a brief description of- of what that was. This was a program that actually was co-sponsored by Indian Health Service, as well as CDC that was out in Dulce, New Mexico. What they did is they went to a high school and did some suicide prevention activities there, but one of the things they did is they went and they canvassed all of the students in the school and asked them about who would you go and talk to if you had a problem. And what they did is, based on those names, they took those students to a retreat and kind of trained them to be what we might call like active listeners because they realized that many of the problems that teenagers run into are not what you would really call life threatening problems, but some vulnerable adolescents respond very negatively to certain things. One of the- the things that they had found out was that three of the leading precipitates of suicidal behavior among adolescents were fight with boyfriend/girlfriend, conflict with parents, and school problems. Well you think, you know that happens to almost every adolescent, but there are some vulnerable adolescents who, when they run into one of those three or all three of those problems, just don't have a way of coping with it. And so what they did, is they trained these adolescents in the school to be active listeners and sometimes, you know, somebody's got that fight with the boyfriend and girlfriend, they know who to call in the school. They didn't go back and advertise it 'cause these were already ones that the students had said I'd go in and talk to them already; but they allowed those students with that training to be able to listen to the folks that just maybe just needed to vent. Now if the person told them, you

know, “I’m gonna hurt myself or I’m gonna hurt somebody else”, that trainee, that natural helper told that person, “I need to take this to an adult, to a school counselor or someone in order to do – to make sure that you don’t get hurt or no one else gets hurt.” They also improved infrastructure within the community so that now they believe that by training these natural helpers, we’re gonna get more referrals. You know, we’re gonna identify people that are in need of help. We’ve gotta be able to say that once we get them to that help, it’s not gonna be a six week or a six month lag time between when they can get to be seen; so they also improved infrastructure. They did what they called “A Rural Outreach”. So they went out to the places where, you know, there are some people who are never gonna come to a behavioral health specialist. You know, they’re not gonna come see because there’s a stigma involved with help seeking regarding mental health so they did outreach. They went out to find the folks that might be at risk and what they found is not only suicidal acts in that community, so deaths due to suicide as well as suicide attempts went down, substance abuse went down, too, in that high school. The other one is what was initially called Zuni Life Skills, and that was the tribe in which it was originally implemented, but they’ve expanded it to include cover; just Life Skills is now the name of it. This was developed by Teresa LaFromboise from Stanford. But what it does also is focus on some of the protective factors within Native American communities and focuses on middle school and high school students to be able to show some evidence that they were able to decrease suicidal behavior in those populations. So definitely, I can send you some of the published articles about those two; and then also a link to that national registry of evidence-based programs and policies in which they describe those programs and others that focus on suicide prevention.

Joe Finkbonner: Have you looked at, or have any research related to using cultural or spiritual integration methods in Indian Country for suicide or mental health intervention?

CDR Alex E. Crosby: We have not done the specific programs. We’ve definitely funded some folks that have done that. And when I talked about the NARA program that was out in Oregon. That was what several of those tribes did, in terms of protective factors, is encourage and actually make as a part of their program some of the spiritual and cultural factors within those tribes that they thought were protective. So whether that was sweat lodges or whether that was definitely connecting youth with elders, you know, who again, can give them some of the balance of you know, that fight with the boyfriend or girlfriend, that’s not the end of it. Matter of fact, you can probably move onto the next boyfriend and just leave him alone. You know, so they- they gave them that kind of advice that, you know, some wisdom can tell you it’s not the end of the world. You know, that fight was not the end of the world. There are other ways of- of trying to deal with some of those issues. But definitely, they incorporated some of the spiritual and cultural aspects.

Joe Finkbonner: What I’ve found is that, the conversations with my elders when I was a kid, was that was the cultural part of it, but also was the opportunity for me to have; for them to get a barometer of where I’m sitting and where I’m going. And – and I think that the more we can encourage those traditional type of interactions, whether that be the basket weaving, the canoe pulling, the, you know, the hunting, all of those things that we can encourage as part of programs

to allow tribes to incorporate their – their culture into this whole system, I think that the more it will be openly embraced by that younger culture because they won't be looking at it as going and getting mental health therapy, instead they'll look at it as I'm gonna go spend time with my elder, or an uncle, or – or somebody who then helps to help them resolve some of the problems that they thought were monumental that all the sudden become, it was a great day to go for a hunt.

CDR Alex E. Crosby: Yeah definitely, just what you were saying, you know, in some of those things, it was a spending time kind of thing. So is going fishing and, you know while you're there, you know, you're just talking over things. I think one person kind of characterized fishing as you're actually doing not much of anything but you're talking a whole lot. And so, it was a time to kind of exchange and, you know, again, like you said, a barometer of where you are, where I am and you know, just the ability to kind of share things. So yeah, definitely those were incorporated into several other programs.

Secretary Adam Geisler: Two things: thank you so much for your presentation. It was – it was really great. One of the things that I think that I'm finding that I'm combatting, not just in my community but I know it's an issue. In general, which is- there are some tribes out there that, unfortunately, have lost large portions of what their identity is based upon relocation, boarding schools, just whole generations of information that has completely been lost which is specific that I've seen in California history based upon the missions and- and the rest of the history that rolled out and in terms of termination. And so, one of the things that we're finding even in my own community, we have a strong, all this is so interrelated; the alcohol, the drugs, the violence, the sex, the DV pieces then the recovery pieces that need to be recurring so everybody is being healed in the process. It's just, I see it all intertwine, but one of the things I think that we're combatting is trying to reestablish what portions of our culture are still intact, and finding those handful of people that are still practicing that and bringing it to the forefront because one of the things, if I'm just being candid with people here, is that, you know, as much as I would like to say I have a ton of people in my community that I could be taking my youth to, to have a conversation about some of these things, the reality is that there is a number of households that don't think like that and it's "toughen up boy, you need to learn, you need to be a man." So they don't have a, there's not an outlet for them to go have that conversation and unfortunately, as much as everybody likes to talk about how wonderful the clinic is, at the same time, yes, there's mental health specialists at our clinics, but there's not really an out-service portion that's going on. Everybody knows in my community to go to the clinic; everybody sees you going to the clinic. They watch you walk into the mental health department, and everybody thinks there is something wrong with you and so there is a hesitation in being able to go after and do those things. Now I will say, one thing that we've done in our community to address this, because suicide is very real, and it was interesting to see the age groups on where it is very real, and that is 100% the things that I am seeing in and around my communities. We actually brought in a community, now we don't have money, but we found a lady that was willing to come up and work with our kids, that does more or less group therapy with the kids in an after school program where there is an open dialog two to three times a week where there having discussions about everything and what we found is, although we might not have specific cultural components that

we can identify for each issue, because we do have our struggles with that, at least there's an outlet there to look at how we want to recreate. Because I think a lot of times we talk about Native people like it's in the past; not recognizing that we're still here, we're still in existence, we're still writing history as we go. There is nothing to stop our culture from evolving and I think that's one of the things we're finding within my own community. So I just wanted to put that out there as an example of there needs to be more support activities, and it's not always money but I've said it before, money helps in finding ways to address some of these pieces, but to find somebody to come in for two hours a day to an after school program two or three times a week to talk to our kids about life, has really been something beneficial. A question that was posed, and this is not my question so I am probably going to butcher it—do you just want to come and ask?

Virginia Hedrick: Hi, it's Virginia again from the California Rural Indian Health Board. My question is on the National Violent Death Reporting System, are there any ability to take into account racial misclassifications? I know in California, we have documented racial misclassification in anywhere from 30 to 60% particularly in hospital and death records so that's the first question and two, California's not in the NVDRS system so are there plans for that and what's the timeline?

CDR Alex E. Crosby: So yeah, the first question definitely has been identified that on death certificates that oftentimes, especially American Indians are misclassified. The states that do have fairly large, or even a significant portion of their populations that are from ethnical racial minorities because some of the issue, while it may not be as great, happens among Latinos also. They definitely try to work within those communities to try to make sure that their identifying people correctly. It doesn't always work perfectly, but they definitely are encouraged to try to do that and especially with our states like New Mexico, Colorado, and Utah, they try to work with the tribes that are there within that state to make sure that especially the medical examiner and coroner, or law enforcement information that may have a more direct knowledge of what that person identified as, that they can try to get that information and feed it into the system. So they do try to do that, definitely it's not perfect, but it's one way that they try to get that information. We have expanded NVDRS as Congress gives us money. So we have money for 32 states right now and so as we get more money, I guess I always talk about, you know, the National Violent Death Reporting System. That first word national is aspirational; we are trying to get to all 50 states plus DC. So we are still moving, as we have funded the states, it's been an open competition so California has definitely applied before. They just haven't ranked high enough to get all the way up to the top or within the funding range. So definitely, as Congress gives us money, we expand the system. So while I can't give you a timeline, you can educate your representatives. Thank you.

Secretary Adam Geisler: Sorry Mr. Chairman, I just find it really interesting, you know that the tag says California area delegate so I gotta ask the question. How is it that we're not being competitive or what is it that we need to do to be more competitive for the program because with the population of a state as large as California, that also means that we proportionately have

probably a larger number of challenges with regards to the mental health issues that are out there and the suicide issues that you are trying to address.

CDR Alex E. Crosby: Well, I can't comment on their specific application, although, when it goes through the objective review, the folks from California who are in the health department do get back a response with strengths and weaknesses of their application so I will have to refer you to the folks in the California Health Department to get the specifics. One of the things that we're looking at as we write the funding opportunity announcement is especially establishing the relationship. As I mentioned NVDRS, it's critical about linking those three different data sets. So one of the things that we are looking for that carries a lot of weight in the application, is you've got to have or demonstrate relationships with medical examiner, coroner, law enforcement, and the vital register. That's where the death certificates come from. So that could be an issue, if you don't have those relationships and aren't willing to demonstrate that they're willing to share data with you, that could be one of the issues there. So there are some things, and again, if you want to directly contact the folks in health department, you'll find out on the most recent application what were the strengths and weaknesses. Let me go back to one of the things that you mentioned, because you talked about some of the issues that relate to some work that we are doing with the Indian Health Service having to do with historical trauma, how those kind of things, not being able to practice your religion, boarding school, some of those issues that created, you know, some generational problems within the American Indian community in terms of passing on knowledge and wisdom and having a stable community. Some of that played a role and definitely some of the programs that look at suicide prevention as you mentioned; there are multiple problems that probably intersect with overlapping risk factors so whether you're talking about interpersonal violence, you're talking about homicide, you're talking about domestic violence, sexual assault, you're talking about suicidal behavior, you're talking about substance abuse, you're talking about unemployment, all those things definitely there are some root social determinants and other things that play a role in that and definitely some of the suicide programs try to look more broadly at what might be some of the underlying issues rather than saying, "oh, that's just a mental health thing and if we just deal with the mental health, that solves it". No, that doesn't solve it. There's some other issues within the community that we've also got to deal with. And again, as I mentioned, some of the programs that are probably more successful, have tried to look at a broader scale of what are some of the issues that are within the community.

Councilman Chester Antone: Is that it, Adam? Are there any other questions? Comments? You have explained it all again. Young lady, are you going to make a presentation?

LCDR Asha Ivey-Stephenson: So I'm here in support of Dr. Crosby and kind of as a back-up as well. One of the things that I just want to thank all of you for the opportunity to present and to be here. We definitely have initiatives within the Division of Violence Prevention that we want to work towards and this really allows us to hear from you to strengthen our efforts in Indian Country so I really appreciate this opportunity. You see me writing down, I'm writing down notes so that we can go back and talk to our states, our partners, our director about some of the things that were talked about here so thank you.

Councilman Chester Antone: I just have a few closing comments. Just for the seatbelts I was telling Holly that the Tohono O'odham Nation received a grant, I believe in that first bunch, and I sent Joe Maloney and Judith Monroe a picture I took in our parade. I rode in a fair parade and there's this little go cart that has the STOP, the acronym on there. I sent it to them and let them know that this started from a grant, I don't know, 9 years ago? But it's still going right now. There is zero-tolerance for seat belt usage over there at major events, but it used to be like at major events, but has since spread and so it's now zero-tolerance for anything like that.

CAPT Hollie Billie: What you just described really is a dream that we have that the work will go on, you know, even after funding ends in some degree, and I think that the example that you just gave at TO is a really good example of sustainability even without direct funding for that specific campaign. The tribe thought it was important enough to keep it going and that's always great to see. Thanks for sharing that.

Councilman Chester Antone: Yeah, that was housed in our community health department. The other thing that with the discussion on the suicide, it's really something that provides the meat to what I heard a long time ago at one of the meetings; the personal meetings if you know what I mean. But the person that brought it up said, "You know, a lot of people say that someone killed themselves because they were heartbroken. But the strange thing is they don't shoot themselves in the heart, they shoot themselves up here because it's the coping that they can't deal with." That was really an eye opener for me because it got me to thinking that it's something that, I mean, I don't know if that's actually the truth, but it lets you think about a lot of things that we can't handle up here that we feel and we don't know why. I think that's where a lot of the conversation with the elders, or with the friend of yours, that should happen and I think the ASSIST Project should embrace that because I think that's probably a good way to put that out there that you just need some help now and then, you just need to talk to somebody with what you're dealing with up here that effects how you feel. So I think that is really good. I heard that from an AA meeting. Somebody said that and that was about 20 years ago.

CDR Alex E. Crosby: Excuse me, yeah, just to comment on what you've said, there's actually been some research that has shown that where this research has kind of measured the degree of depression versus the degree of hopelessness. Now the hopeless is not a psychiatric diagnosis, but he actually found that in terms of looking at a risk for suicidal behavior, it was the hopelessness that was a bigger risk factor or a predictor, predictor is probably not the best term, but it was a better predictor of whether the person would go on to engage in suicidal behavior than clinical depression. So just as you were saying, you know, hopelessness is a big issue in terms of trying to address that and prevent suicide.

(Audio cuts out.)

Councilman Chester Antone: A 10-minute break, I know you guys want to move around a little bit, so come back in 10 minutes and we'll start with the budget presentation.

CDC Budget Update

Councilman Chester Antone: Also, I need to let everyone know in here that we need to limit our laptop use and cell phone because it is disrupting the recording of the discussions according to April back here. But yeah, if you could do that, that would be good, especially with these next two presentations. With that, I'm gonna introduce the budget person there. You just introduced yourself to me but would you introduce yourself and begin your presentation?

Dr. Deborah Lubar: My name is Deborah Lubar and I'm the director of CDC's Appropriation and Budget Formulation office, which is part of the Chief Financial Office at CDC. And our roll at CDC is to work with the White House and Congress on CDC's appropriations, so I'll tell you a little bit about the process before I get into the content to make sure I know how this works. There we go. With me is Michael Franklin, who I think you all have met before, and he actually gets to spend the money; my job is just to bring it in. It's not unlike my household really. So he can answer questions about actually how the budget is operationalized. My job is working on proposing the budget and then working with Congress on what our budget will actually be. I'm gonna just give you an overview of how this is done. We just last week, last Monday, released the President's Budget Request for 2016 and I know that the National Indian Health Board has done their analysis of that budget which I am anxious to read. We are part, of course of the HHS budget, but we do have our own submission to Congress that is very detailed. I have one down here, it's big. It looks like this and it's on our website. And we do this every year and the way we get to this document is a very formal and very internal administration process, so I just want to give you a sense of that. We each year, in the Spring, make a proposal to the Department of Health and Human Services for what our next year's budget will look like so we will very soon be working on that for 2017, which seems very far off, so this process starts way ahead of when Michael gets to spend the money. We usually are given some targets for the targets for the amount of money we can propose and some guidance on what kind of proposals the department is looking for. And there have been times, right when I started at CDC, where we were asked propose increases; more often during my tenure here, we've been asked to propose decreases or level funding. And, you know, typically, this is an incremental process so we start with what did we have last year, and where are places that we see as needing new investments and that process sometimes is very broad if we think there's lots of opportunity to ask for new resources, we'll involve many, you know, all of the centers, institutes, and offices. Sometimes it's been really narrow. If they said to us, "You get one proposal," we're not gonna ask every center to dream up three proposals, that's not a good use of time. So it's sort of depends on the guidance we get, what we propose to the Department. That then leads to a negotiation; we present it to them. There's a hearing where Dr. Frieden presents our request and that leads to a negotiation for what our proposal will be to the White House, so that's our second submission of the year and that happens in the Fall. We then have hearings with OMB, we get a lot of questions from them, and then we get final negotiations and decisions from OMB; use to be over Thanksgiving, this year it was literally Christmas Eve where we got final decision and then we produced this final document. So that's kind of how we

get to the President's budget request and it is a request, and I'm sure you all will hear as soon as the President, or maybe the day before or week before, as soon as it comes out, everyone on the Hill says, "well that is dead on arrival". Right? So why do we do this every year? You know, it was released on Groundhog Day; what's the reason for that. So the reason, the best use of this that I see for the Agency and the way that I try to position us is to show what our priority areas are and where we really need increased resources. Now in order to do that, cuts are proposed and we wish we didn't have to propose any cuts, but it's part of this process in this negotiation that we have to hit a certain at the end of the day and it's a lower number than we would like. But this is the beginning of having those conversations with Congress. What do you really need new money for? Are there some places where you could have some savings? What are the members' priorities and how do they align with what the Administration is proposing? And so within that process, many groups have a voice at different points in the process. I would say, you know, at any point, CDC is listening to what the public health community and advocates are looking for out of us in terms of investment. Talking with HHS during that process, especially if you time it, for when they are receiving our request can influence those negotiations. At least in our case, The Office of Management and Budget, which is the White House office that manages this process there, very active and they talk to a lot of groups about what their priorities are. And then of course Congress is really gonna be the final decision maker and there's lots of touch points there. So, as I talk about this, just a reminder, this is the beginning of the 2016 congressional process, so you should be thinking about areas where you have concerns or where you feel support and can communicate that to Congress. And at the same time, if there are things in here that you would like to see more or less of, there are touch points in the Administration where you can voice those opinions as well and they do make a difference. It's not a public process, somebody asked me, "Is there any public comment?" It's this really closed, embargoed process, to the point where I'm not allowed to tell anybody what's in here until the President releases the budget but that doesn't mean that people aren't influencing it; it just means it's happening without the formal comment periods and things. So, like I said, we kind of start with what we had the prior year. This year is FY2015 and we had just under seven billion dollars in annual funds. So you all know about the Vaccines for Children Program, that's not included in here, that's not something Congress has to decide on each year, it just happens. There are some areas that are like that as well. What you see here is that 6.87 billion-dollar number includes budget authority, which is sort of regular appropriations. It includes The Prevention and Public Health Fund which is authorized by ACA and directed by Congress for the last two years; almost all of it comes to CDC. And then that last ugly acronym is The Emergency Fund that HHS manages and we sometimes are funded from that. In 2015, we spent a lot of time working on emergency funding for Ebola. The first chunk of that came when we were under a continuing resolution that started on October 1st and that's 30 million dollars; and then if you compare the 2015 levels to 2014, for us, that's about level. There was about a 40-million dollar increase; it's going in the right direction. The last bullet on here talks about the emergency funding for Ebola which is just under 1.8 billion dollars. That was contained in the same bill as our regular appropriations and it's available for five years. Most of our funds are available for one year; that's why you see so many things funded on September 30th. So this gives you an idea of the trend in CDC's budget and you can see it's pretty steady. FY2013 was the year where there was an across the board sequester

and we also at CDC lost a lot of our prevention fund resources and so, we got kind of a double whammy and that's why we look so low there. We're glad to have recovered from that. The 2016 President's budget request that I'll be speaking about is slightly higher than the 2015 enacted which is like a first for me. It's been lower every year, and then I go and talk to people and they say, "Why are you proposing to cut yourself?" And I say, "Well, you know; it wasn't our first choice." This year we didn't have to do that. So this budget requests 140 million dollars or so more than we had in 2015, and it continues priorities that we've been requesting funds for- for the past year or two and I'll go over the priorities in some detail. So, any questions at this point? Any questions you want to voice?

Councilman Chester Antone: I have one. You said that this is the beginning of the 2016 budget process. So, that document there, that is where you would include, maybe not specifically an increase in certain funding, but that's where you would address a policy change as far as, let's just say, we want to address some funds to be designated for tribal people. To designate a fund, that's where you would go to do that?

Dr. Deborah Lubar: There are several different ways that that could happen. I neglected to show you, but CDC's budget is very directed by Congress; it's very complex. This is what our table looks like. There's 150 different lines on here that are mostly disease or risk factors so there's not a lot of places where groups like yours that are interested in populations can really see yourselves in our budget and I think you're in lots of places in here, and there may be more places where you would like to be. For some programs, and we talked about this a little bit yesterday, some programs have an authorizing statute of law that tells us how to run the program and that might say you'll be making grants to states, tribes, and territory. So an example of that is The Breast and Cervical Cancer Program where tribes are explicitly included in the law. You might have other laws that tell us how to run a program that leave tribes out either intentionally or just because nobody put them in and we have to examine well are we able to if we choose to include tribes. I was involved in a story like that with The Wise Woman Program where we were funding tribes and then we noticed, oh, that one word is really not in that part of the statute; are we ok there? But for the vast majority of CDC's programs, we do have some discretion about who our grantees are. And so a program can choose to do that when their funding cycles are changing; when they're doing strategic planning, when they see new epidemiologic patterns and they know they need to address a new population. That could be reflected in here, but if it wasn't reflected in here and a program still saw that need in the intervening time, that would not stop them from making that kind of a decision. So we do try, and like I said, this was started being produced over a year ago, we do try to get programs to tell us what changes they see upcoming, but sometimes things change between the times we start this process and the time we actually get the money; so that's one way that change could take place. We also, as you can see from our budget table, get a lot of direction from Congress. So in the Appropriations Bill, we have both the bill language which is pretty sparse, and then we have these long reports that each chamber does and that we get as a conference report with the bill and those will say to us, "We're appropriating this much money for diabetes and we expect you to do A, B, and C with it." And sometimes that might say, "We expect you to fund these kinds of grantees with it." And again, that might explicitly include

tribal organizations, it might implicitly exclude tribal organizations if it says, "These funds are for state health departments," or something like that. So it's varied across CDC, but this is one place where you might see that kind of proposal.

Councilman Chester Antone: Yeah, that's what I was getting at because I know that CDC thinks of funds as not favoring one race over the other but when you look at that, we're not talking about race, we're talking about government-to-government. And that's what I was asking about. As far as I know, when you, let's take IHS for instance, they have this budget formulation process that they go through. Each area talks about what they are gonna do, what their priorities are, and then I believe this week they are meeting in D.C. on the 2017. So this is where they begin to prioritize certain things that needs to be in that budget and so and up the line. But here in CDC, how does that budgeting process begin and continue onto when it's enacted by Congress. How does that happen?

Dr. Deborah Lubar: So that's the process I was describing at the beginning where we'll get some guidance from the Department on how much funding we can propose. And we typically start with, what are we funding now; where can we make changes? I think for other Agencies, formulation is a very different kind of project. If you are providing services and you have an eligible population, then budget formulation is really about calculating who is eligible; what are the cost of services going to be; how are we going to fit that within our budget? Because CDC's programs are very different from each other and very few of them are service-based, with a few exceptions, our budget formulation process is not quite as mathematical as that, and it's also not quite as consistent across the Agency because our programs are implementing different kinds of intervention in different settings. So I don't know, Judy did you want to say anything more about that? You look like you might have a comment.

Councilman Chester Antone: I was just going to ask about the discretionary authority part. So exactly who has discretion over those funds? Is it the CDC Director?

Dr. Deborah Lubar: The discretionary budget is just the part of the budget that Congress is deciding about each year and they, as I said, provide us with a lot of direction. So, Congress has given us 150 or so different activities that we need to fund at a certain level. So for example, they've said, you know, you're heart disease and stroke program will have 58 million dollars in budget authority and 73 million dollars in PPHF funding and we're bound to that level for heart disease and stroke; and that's a big one but we have many smaller programs as well. Within that, we sometimes get directives from Congress that we will do certain things with that money. This should fund state health departments to do interventions to prevent, to control blood pressure, something like that. So, sometimes we'll have direction like that, sometimes we won't. Within the bounds of the amount that Congress provides and the direction that they give us, CDC does have some discretion to decide how to use the funds to achieve those purposes. And ultimately, that's the Director's discretion, but it does get managed very much at a program level where the scientist and public health program people are doing the work.

Councilman Chester Antone: Yeah, that's what I wanted to get that answer; that the Director does have some discretion on the budget and especially on the discretionary side, but my final question will be how much discretion does he have when you have to go into the actual budget to find those discretionary authority?

Dr. Deborah Lubar: It's really determined on sort of a line by line basis because we have to look at what directives we have from Congress. So this is just our proposal and there may be some things in here that the White House is going to hold us to, that kind of thing. It's really the Congressional Appropriations Bill that sort of sets the parameters in each of these areas on what we can choose to do. So if there's a specific area that you are interested in, we can provide you with a sort of what the framework that Congress laid for us was. And I do think this is challenging because you all are interested in lots of different diseases and risk factors, and they don't all run in exactly the same way so it is almost a case by case basis, and that's really based on the way that Congress directs the funds when they provide them to us.

Councilman Chester Antone: Ok, well thank you very much. I still think there is some ways around that.

Dr. Deborah Lubar: I agree, and I think that one place where you've really seen that discretion working with tribal concerns is in the Chronic Disease Center, and I know you talked to Dr. Bauer. That's an example of we had new funding for heart disease and diabetes. We had some funds that were base funds. We had had them the prior year and we knew that they needed to be used for heart disease and diabetes and we knew they had to be used in certain ways but the way that the Chronic Disease Center chose to package those dollars was at their discretion, you know, with approvals from inside of CDC; so there definitely are ways to do it.

Councilman Chester Antone: Mr. Geisler.

Secretary Adam Geisler: Good Afternoon. I appreciate the information that you're sharing. Sometimes my comments can be a little crass.

Dr. Deborah Lubar: I work with Congress, it's fine.

Secretary Adam Geisler: And I work with tribes so I think we're on the same page. One of the things that I think the Chairman was getting at is that, and it's not to be combative with you over this situation, because I do respect the juggling act that you are trying to do, we operate our own governments in itself in trying to balance our own budgets and meeting the needs of our communities. So I can respect the challenge that there is; however, you've probably heard other people before me sit at this table and talk about the fiduciary trust responsibility of the United States government. And I believe what the Chairman was expressing a few moments ago, was that the difference between tribes as independent nations, and municipalities or states, is that we are sovereign governments and that responsibility does reside within each federal agency underneath Congress and Congress has that responsibility; and, you know, I'm not here to try to

give you a history lesson or to lecture you over this, but at the same time, I think what's frustrating is that, what we learned this morning is Dr. Bauer, is there 16 total?

Dr. Deborah Lubar: Oh gosh, I hope not. I think there's 12.

Secretary Adam Geisler: Is there 12? What we learned was that 75% of the funding going out into Indian country that's supposed to have some discretionary ways in which that's being exercised and dispersed is coming from her program and her program alone. And what's frustrating to me, as a tribal leader sitting here, is understanding what the trust responsibility is. But keeping...moving beyond that point of discussion, looking at other funding mechanisms that are out there, there is direct appropriations. I'll use Transportation as an analogy, I've been given all morning The Travel Transportation Program; we have our own set aside direct underneath Map 21, so this idea this idea of creating a tribal specific source of funds to meet the needs of the community that you're supposed to be servicing in the first place, that you have a responsibility to be servicing based upon the history of treaties and executive orders, I think it's frustrating to hear that that is not a recommendation coming for the President, or from you to the President. And I recognize again that you're trying to keep everybody in the same group in terms of the way that the competitive natures of these funds; however, we're not the same group. Department of Labor actually sets aside our ability and views us completely separately when it comes down to labor issues with regards to TERO. So I can give you example after example after example of where we are not a group, we are a sovereign nation that has a responsibility in the relationship with the federal government; therefore, I think what the Chairman was expressing was that why do we have to go through this discretionary process? Why can't there be a recommendation coming out from yourself to the President, or from the President to Congress, and making that recommendation to carve out some of these sections because the term that I've been hearing all morning long about surveillance, which is kind of a creepy term, I don't like it; there should be a different word.

Dr. Deborah Lubar: We have to remind scientists that other people get a little creeped out by that term.

Secretary Adam Geisler: Exactly. I think that one of the things that we face in order to be competitive is the ability to collect the data that you're looking for us to compete. And so, you know, it would be great to see the CDC come out with a funding mechanism to develop that, or better instill that within the tribes or organizations that are currently out there doing this work, because I think that is what you're going to find. I mean, all morning long we've heard about data collection and the lack of information that's coming out of the Indian Country and then it's like, ok guys, well go be competitive for the funds out there with everybody else and it really puts us at a disadvantage. So, that's my soapbox.

Dr. Deborah Lubar: I very much take your point. In terms of a recommendation like that and how it would make its way into the President's budget, I can give you a little bit of information about that. I can't ever talk about the content of what those negotiations look like, but any

recommendation that we make to The Department of Health and Human Services in this budget, we have to get the Secretary to agree with us on. So that's step one. Step one is that we make the recommendation. Step two is the Secretary and her counselors need to say yes, we're going to let you put that forth to the White House. Then the next step is we have to convince the White House. We have made recommendations in this process that I promise you are not in this document and we had some things that we didn't want in this document that I promise you are. So it's not just about getting us to make any recommendation in this process. It's that we have to have receptive people throughout the process in order for it to make its way to the President's budget. So I am providing that to you as input to you if this is a line you want to pursue, that working with Judy and with this counsel is a starting place for sure, but it's not an ending place.

Secretary Adam Geisler: Then my question would be for Dr. Monroe. What is going to take in order to get the secretary here to have this conversation? What I find...what I mean...that's not that outlandish when you look at what the expectations are in terms of Indian Country and the way we work with other Secretaries underneath the President in the Cabinet. So what does it take in order to have that dialog? Because I think, a lot of the frustration that you'll hear with a lot of the comments really boils down to the fact that we're looking to try to have that conversation and understand where that person is standing.

Dr. Judith Monroe: So I do believe, and as Deb said, this body as CDC's TAC, you all do have the opportunity to present to us your recommendations that we'll carry forward. With Secretary, the STAC, The Secretary's Tribal Advisory Committee, is an opportunity to get those kind of recommendations directly to the Secretary; so the members of the STAC. And then you have your opportunities to raise your voices elsewhere. But those are the two formal avenues that we have, the TAC and the STAC.

Dr. Deborah Lubar: I would just also point out that a lot of people in Congress say, "Yep, that's dead on arrival." So if there is not a recommendation in here that is not the end of the line for you either in this process. It just is the beginning of the next part of the process. I'm curious about how these other, and I'll do a little research, how these other unsatisfieds got established; whether they were requested or administratively developed or statutory, yeah.

Michael Franklin: I think we're not aware of that. I'm sorry, I'd just like to add to everyone else, that was good information that you provided. We are not aware of that but, as Deb said, we will look at that.

Councilman Chester Antone: Maybe you can go ahead and proceed with your presentation?

Dr. Deborah Lubar: Yeah, we don't have a lot of times I'll hit some highlights. These slides, which I think will be available to you afterwards as our summary documents about our budget on cdc.gov/budget, show where we are requesting increases and the two that are underlined are some high priority areas and the others you can see there. I think yesterday, the ones that on this slide that folks had the most interest in, was probably the antibiotic resistance work that we are

trying to do to protect our ability to use antibiotics in the health care system. We also spoke a lot yesterday with the group on the drug overdose prevention work, which seems to be a priority for your groups as well. And then lastly, our laboratory safety is really about strengthening CDC's ability to support the public health system and do our investigations. So this slide got a lot of conversation yesterday so I wanted to make sure we hit it. It may be the last one we get to. These are reductions that are proposed in this year's President's budget. Many of them are the same as last year's so if you were following our budget last year, you will recognize these. A few that I know that were of concern to NIHB yesterday are the Cancer Prevention and Control Cut which continues a proposed cut to the Breast and Cervical Cancer Screening Program, as well as, the Colorectal Cancer Screening Program. Those cuts started being proposed around the time that ACA was kicking in that insurance coverage was expected to cover many of the uninsured people who were eligible for those programs. That cut has been proposed for a couple of years. Congress has been level funding that program. I don't know that this year would be different but it's one to watch. The Immunization Cut, I'm skipping down a little, is the same idea; it's this would be a cut mainly to our public vaccine purchase, and we continue to be very vigilant about making sure that our vaccines, that our immunization infrastructure in this country is supported because the infrastructure that we provide; is not just for the vaccines that are purchased through the 317 Program, it's not just for VFC, but it's for the entire system. So that cut would largely come out of vaccine purchase and because VFC covers uninsured children and all insured people are now covered for vaccines without co-pay, the group that we tend to be buying that vaccine for is uninsured adults. So, that is a hit there. So we also maintain enough publicly funded vaccine, or we try to, for outbreak control because we don't really worry about who's paying for it if we are trying to control a measles outbreak or something like that. The other two that we talked about at some length yesterday were the cuts to the REACH Program, Racial and Ethnic Approaches to Community Health, and the proposed cut to PICH, Partnerships to Improve Community Health, that cut is new this year, the PICH cut. The program, this would be its third year. And I know that those are both funding streams for which there are tribal grantees. So again, these are proposals. The REACH cut has been proposed before. I do think that the community programs were very much supported by the Senate Democrats and by Chairman Harkin in particular so we do have come changes and decision makers that I think, if those cuts are not something you like to see, you probably have some new friends to make to talk about that. So that sort of the state of the reductions. Is there anything else on those?

Ok. I learned yesterday which ones would be of interest. So these next slides talk a little bit about the needs and like I said, the way we try to use this President's budget process in particular is to shine a light on where we are under-invested. And one area that is a huge highlight this year not just to us, but across HHS and the U.S. government, is antibiotic resistance. So every time I hear the scientist present about this I pick up little scary things, and I don't really want to be the scary one, but I have heard them use this term, "The post-antibiotic era." We hear a lot about the "pre-antibiotic era" when infectious diseases were the leading killers in this country and between vaccines and antibiotics and other advances in medical care; that's not the case anymore. The concern we have here is not just about infectious diseases though, it's our health care relies on antibiotics for a lot of care and treatment that we take for granted. So if you are doing

chemotherapy, you need to be able to treat infections that occur in people with compromised immune systems. If you get injured in a car wreck and you need surgery, you have to be able to prevent the infections that can come with that to survive; so it really puts our entire health care system at risk. These numbers are bad enough. Two million illnesses and 23,000 deaths from antibiotic resistance. But if we were to compound that with ineffective cancer treatments, diabetes treatments, surgeries, joint replacements, you know we really lose our modern health care system. So that's what we're looking at here. Since we don't have a lot of time, we have goals that are cross-governmental goals in this area. Our request is for 264 million dollars in this area. A large amount of that, about 80 to 85% of that would go outside of CDC to state and local health departments, to universities to drive towards these results in a five-year time period. And we think that if we can do this effectively, we will prevent about 37,000 deaths, save almost 8 billion dollars, and reduce infections by over 600,000 a year. So that's the antibiotic resistance in a really brief nutshell. We have some good materials on the website. I hope y'all will look for it if you have an interest.

I think...what I learned yesterday, is you already know about the prescription drug abuse epidemic. We really see curves here that are scary; the increases are huge, the costs are high. When you think about why it's happening, this line graph is really stunning. The purple line is the increase in opioid sales. Those are legal sales. The green line is the increase in opioid deaths and that's a pretty high correlation. This is what we're seeing in terms of trends. Last year, for which we have data, was a little bit in reduction in opioids, a little bit of an increase in heroine. So part of our request really focuses on that connection and examining how people may be moving from one to the other. So we've already been doing some work in this area. In 2014 we used some of our injury prevention funds to support five states to work in these areas in a modest way and we are already seeing some good results from that even though the funding has only been out in the field for only six months I think. In 2015 Congress appropriated 20 million dollars for this purpose and so we're preparing to make awards there. Those will fund up to 17 states. And we're really working on that top line in the graph I showed you about trying to reduce inappropriate prescribing and use existing systems to identify problematic use patterns. And in 2016 we are requesting enough funding to fund the whole country for a pretty robust set of activities. Every state except for one, and I think its Missouri, someone from Missouri is here and I'm wrong, I'm sorry, has a prescription drug monitoring program that's kind of the bare bones of collecting data about opioids. We want those to be active, real-time tools for doctors and pharmacists, and regulators, and public health professionals to use to look for the problematic use either at the patient-level, at the provider-level, or at the systems-level. We are working with insurers and health care systems in those settings, as well. So we have some impressive results. We know that when these policies are put in place, when these programs are adopted, you can see pretty dramatic outcomes. The one I'll highlight here is the Florida 50% decrease in overdose deaths from Oxycodone in two years. They really cracked down on pill mills, but you can see that there's other states that are experiencing similar things by using some of these prevent interventions.

A word about our global health work, we did get a big infusion of funding with the emergency funds. We do want to continue to stop outbreaks where they start and there's some funds

56 This transcription represents the meeting minutes/discussion, etc. of the February 2015 Tribal Advisory Committee Meeting and 12th Biannual Tribal Consultation Session and does not necessarily represent the Centers for Disease Control and Prevention's views or policy."

requested in this budget to strengthen that effort including supporting the emergency funding over the long haul. And then, I didn't even know that was animated, there you go. In our laboratories, we have had a few incidences in the past year that have caused us to look very carefully at our safety and training systems, and we've put a lot of policies and procedures into place. We've stated some of the training work as well and we've done a lot of that within existing resources but there are 20 million dollars requested in this budget to help us do the things that require increased investments. So those are the highlights of the priority areas and I'm happy to take any additional questions that you have.

Councilman Chester Antone: Any additional questions? You're right at 3:30. If not, thank you very much.

Dr. Deborah Lubar: Thank you for your time.

Councilman Chester Antone: I did learn something from this exchange here. Thank you.

Dr. Deborah Lubar: I'm glad to hear it.

Councilman Chester Antone: Thank you.

Michael Franklin: Yes, thank you.

Hepatitis C: A Health Disparity for American Indian Populations

Councilman Chester Antone: Before we get to the Hepatitis C, I'll make an announcement. For TAC, there is a dinner meet and greet at Tin Lizzy's Taqueria Cantina from 5:30 p.m. to 7:30 p.m. Please contact Deon Peoples for more information and I believe that's Deon right there, so contact him if you're gonna attend. Ok, now we're gonna go to our last presentation which is the Hepatitis C: A Health Disparity for American Indians Populations with John Ward.

Dr. John Ward: Right here.

Councilman Chester Antone: Hey John. Go ahead and proceed.

Dr. John Ward: Thank you. If I can get my slides up...excellent. First of all, I want to thank you for giving me time on the agenda to talk about Hepatitis. I really appreciate the opportunity because we're really trying to face a challenge around Hepatitis C; we really would like to get the advice and consultation from this group about how to proceed. What I'd like to do in my few moments, is to go over about Hepatitis in general. Quickly, just so everybody understands a little bit about Hepatitis for those who are less familiar with it. Describe two successes within American Indian communities in combating Hepatitis-and that's regarding Hepatitis A and Hepatitis B- and then talk about the current challenge facing American Indians and really the rest of the country for

that matter; which is the rising morbidity, mortality, and transmission of Hepatitis C in the era of curative treatments for this disease. So we'll be talking about three types of Hepatitis. Hepatitis A is caused by Hepatitis A virus which is spread by person-to-person contact, or through poor sanitation whereby food, water becomes contaminated with this virus and this is transmitted by the so called fecal-oral route; resulting in acute inflammation of the liver leading to illness, jaundice, etc. But fairly low rate of mortality of only several percent with the greatest risk of that mortality being the older persons. The older you are, the more severe the disease is. Indeed, you get a lot of asymptomatic transmission among young children; so they do not get ill, but they become vectors for others in the community who do. Hepatitis B and C are more blood borne and sexually transmitted related viruses particularly Hepatitis B as it relates to sexual transmission; that's less the case for Hepatitis C. B and C cause most of their disease through chronic infection where they set up housekeeping in the liver, and then become silent infections over decades which slowly damage the liver leading to cirrhosis and to liver cancer. Hepatitis B virus is a cancer causing virus in its own right, a so called oncogenic virus; whereas Hepatitis C virus causes cancer because of the scarring of the liver. So the sooner you can cure that virus, and before fibrosis sets in, the lower your risk of liver cancer going forward. As far as prevention, both A and B are prevented by vaccination. Hopefully, as most of you know on the panel today, Hepatitis C we do not have a vaccine. There's no vaccine candidate on the immediate horizon, so other measures have to take center stage; blood safety, harm reduction and health care, harm reduction among injection drug users, safe sexual practices among certain populations, and then clearing the virus through testing, care, and treatment. So all of this contributes to the chronic liver disease being a major health disparity for American Indians and Alaskan Natives. As you see here on the slide, it represents about 7% of all deaths. It's about the fifth leading cause of death for American Indians versus the eleventh leading cause for White Americans. Mortality has increased related to liver disease; much of that is related to cirrhosis and you get a confluence of risk where you have Hepatitis B and Hepatitis C being preventable infections, and then alcohol abuse serving as a co-factor. We often talk about alcohol being the gasoline that's thrown on the embers of inflammation caused by viral Hepatitis accelerating that disease progression towards cirrhosis and liver cancer; so the combination of those is a deadly mix. So let's talk about some success stories. Hepatitis A was a high incidence disease for many years, before the era of vaccination began in the mid 1990's where you had epidemics of Hepatitis A occurring after about every 10 to 12 years representing newborns and young children becoming susceptible after birth and becoming infected. In an epidemic, susceptibles become infected and then the epidemic subsides. So we begin to put vaccine policies in place in the mid 1990's beginning with a focus on American Indian communities in the western part of the United States targeting young children. That was then extended to the vaccination of all children in these high incidence areas. Many of those states representing where American Indian nations and reservations are located as well as Alaska. And then in 2005, recommending this vaccination for all children beginning at 12 months of age. As you can see there, the impact has been tremendous with a 118-fold increase in vaccination among American Indian children beginning very early. And there's examples of evaluation programs targeting American Indians in Maricopa County, Arizona and in Arizona State as a whole; and as a result, we've seen dramatic declines in Hepatitis A incidence in response to that development of effective Hepatitis A vaccination programs. And this is

represented on this slide here, if you look at the American Indian and Alaskan Native bar represented in white, you see it has fallen over the last 12 years, as depicted in this graph so that the disparity versus Whites, for example, has gone away; and so we no longer have that disparity of American Indians versus Whites. Regarding Hepatitis B, it's important to vaccinate as soon as possible, preferably beginning immediately after birth. Why is that important? Because the virus is spread very readily at the time of birth from mother to child or when the child is very young. And it is particularly problematic because the earlier you are when you're infected, the higher the likelihood that you're gonna keep that virus for a life and the higher your risk for liver cancer. Indeed about one out of every four children who become infected will die of liver cancer or liver cirrhosis in the absence of testing and treatment. So we have set about a goal of eliminating Hepatitis B transmission through vaccination beginning in the early 1990's targeting infant immunization including Hepatitis B vaccine in the routine infant immunization schedule, catch-up strategies for those who were too old to benefit from that infant vaccination program; and then recommending a birth dose, that before that child leaves the birthing facility, they receive a Hep B vaccine. And again, there's been progressive adoption of that over time. We have about 90% coverage of infants receiving the Hep B vaccine, and we progressively increased vaccine coverage for newborns, to it's about 70% now nationwide from less than 50% ten years ago. So we're making some great progress in assuring that infants are not becoming infected with Hepatitis B, and that extends to American Indian communities; as you see again in this graph that we've been able to eliminate this health disparity. So working together, we can make profound differences that have real health impact for individuals in communities including those you are representing here today.

Now let's talk about Hepatitis C, the current challenge. Hepatitis C virus was discovered in 1989, so about 25 years ago. Before that time, it was known as non-A, non-B Hepatitis and we didn't have a test for it. People knew that if you got a blood transfusion, you had a high likelihood of becoming infected with this unknown agent at the time. The virus was discovered, including with the help of the CDC laboratories and serologic tests were developed to begin to protect the blood supply and to understand the epidemiology of this disease which showed that it was a very major infection for people who inject drugs. People have other forms of drug use like inhaling cocaine for example. Some sexual activity is associated with HCV transmission; and transmission in healthcare settings. Particularly, before we had universal precautions that were put in place for the AIDS epidemic in 1990's. I don't know how many of you at the table or in the room were trained before that time but healthcare was a much scarier place as it relates to infection control before this virus was discovered and we find that about half the people, when you ask them how they got infected, can't tell you and I think a fair proportion of those were infected in these various healthcare settings. Once infected, you have about a 75% likelihood of remaining infected for life and therefore being at risk for liver cancer down the road. So what we have, we have a birth cohort affect. I may be showing this in the next slide, whereby this incidence that was very high before the virus was discovered with about 300,000 people becoming infected every year in the 1980's how now become a wave of prevalence of people moving through time and progressively becoming ill with Hepatitis C and dying of Hepatitis C. This is just one curve showing that we've modeled the likelihood for this so-called birth cohort of about three million people

infected with Hepatitis C that in the absence of interventions, of testing, care and treatment, that about half of those people will develop severe cirrhosis and about almost a million of those people will die of their Hepatitis C over the course of their lifetime. So what we would like to do is change that curve, flatten it out, prevent these deaths and improve these health outcomes. And this just represents this birth cohort phenomenon. This is from our NHANES, the National Health Survey, showing two points in time of that survey and so those two waves just showing that people are getting—this high prevalent population is getting older so you can't really look at it by age because the age changes very year so you have to look at it by birth cohort. So we've targeted the so-called "baby boom" population, people born between 1945 and 1965 because they have a five-fold higher prevalence than other persons. About 80% of all people infected with Hepatitis C are in this cohort and about 3 of 4 people dying of Hepatitis C are in this cohort. So we moved to recommend that everyone in this cohort be tested one time for Hepatitis C and if positive, be referred for care and treatment because CDC believes that everyone should know their status and being in care to know what they can do to protect their health, prevent transmission to others and receive an evaluation to see what needs to be done for their Hepatitis C. Now as it relates to American Indians and Alaska Native populations, we have done some analyses which we have published in the Peer Review literature and this is just one example, showing the increases in Hepatitis C-related hospitalizations, particularly for this group that represents baby boomers. And so this is one example of the health disparity that I believe that American Indians and Alaska Natives are experiencing with Hepatitis C. Similarly you can see that the mortality rate related to Hepatitis C is much higher for American Indian and Alaska Native populations than for other racial and ethnic populations in the country and that that disparity has actually widened with the more recent data available. And indeed, I was just looking at the 2013 data yesterday because it had just come in and this mortality rate has gone up to over 12 per 100,000. The other aspect of Hepatitis C that we're concerned about is incidents. We're concerned about prevalence because people are getting sicker and dying of this disease, but there's also an epidemic of new infections. Ms. Lubar mentioned this opioid prescription epidemic and it is causing overdose deaths which is a call for public health action and that's where the acute outcome of this opioid prescription epidemic, sort of the chronic infection and disease outcome of this is Hepatitis C. This started in New England about ten years ago and slowly progressed across the nation whereby last year about 22 states reported a 50% increase in the number of new cases of Hepatitis C. And we published on this last summer to show that this is young adults below the age of 30, about equally likely to be male and female, many report a history of abuse of oral narcotics- prescription narcotics and then they progress to injection of those narcotics or of heroine either because of tolerance—you have to take more to get the same high—or because of cost. Heroine is cheaper than an Oxycontin pill. And you see that the states in red here are the ones that are experiencing the largest increases. So we're very concerned about we need to get a handle on that. Now I'm afraid that it's not just an abuse of oral prescription opioids but that we have spawned an epidemic of heroine that goes outside of this prescription intervention which we have demonstrated effectiveness of and we have to look at these other aspects of this epidemic and so we are striving to do that with our resources. And I would like to hear from the committee if you have any experiences with that. I have spoken to the Cherokee Nation in North Carolina health authorities. They are experiencing this increase in

North Carolina among the Cherokees there. So this just demonstrates the incidents of acute Hepatitis C. So in contrast to the declines that we've been able to achieve through Hepatitis A and Hepatitis B, we have the reverse for Hepatitis C among American Indians. We actually have a widening disparity for incidents in Hepatitis C, so we have a prevalence problem and we have an incidents problem that we need to address. These, again, show you our guidelines for testing, so they include this birth cohort approach as well as a risk-based approach. This CDC recommendation was endorsed by the U.S. Preventive Services Taskforce in 2013. So that should allow this testing to be covered in many instances without a co-pay for people who are seeking testing to be covered by their health insurance plans. So helping to reduce cost as a barrier to this intervention. We don't have a lot of information about screening of Hepatitis C for American Indians I regret to say. This is just one study in Omaha of only 243 patients; the clinic is used by a number of tribes as you can see there and they found about 11.5% prevalence of antibody positivity in that group with drug use being a predominant risk. In the Northern Plains, a couple of obstetricians took it upon themselves to begin screening pregnant women for Hepatitis C and they found about a 6% prevalence. There's about a 1% overall prevalence of Hepatitis C in the country as a whole just to give you some context for that. Screening persons born in 1945 to 1965, we have been working with the Indian Health Service to implement a Clinical Decision Tool whereby in the Indian Health Service electronic medical record. If someone checks into the clinic with a date of birth in that birth cohort, a prompt pops up reminding the provider that that person needs to be tested for Hepatitis C, and they have seen a remarkable increase in testing and they estimate that almost a third of the baby boomers in the Indian Health Service clinics have now been tested for Hepatitis C which is really a remarkable achievement considering we've only recommended this for several years now. And my apologies for the Word program that always changes IHS to HIS. I see that other people have that problem too, so interesting. So we haven't yet gotten feedback on the number of positives they're finding. Just anecdotally they told me they have been surprised where prevalence is high and they have been also surprised where it was low. So it will be interesting to get that data for priority study going forward. We're also worried about what we call the care continuum for Hepatitis C. Testing is not enough. Testing really is only the start of the health benefit, it's not the end of it and you have to have this care cascade for certain services to be provided for that testing to have this full public health impact. So we're done this analysis for the country as a whole to show that only about half the people infected know their status. A smaller proportion have been tested to confirm their current infection status. As I mentioned, a certain number clear the virus on their own, and then it gets progressively poorer how many people have actually been evaluated for care, been offered care, started care, and been successfully cured of their infection. So we want to improve that care cascade beginning with testing. We have shown this is a cost effective intervention comparable to other preventive services that are considered to be routine good medical practice in the country and this is a bar graph illustrating that as compared to flu vaccination, breast cancer screening and others that you see represented on this slide. The other you know aspect that really improves the benefits of this intervention is the breakthroughs in Hepatitis C treatment. Just three years ago we had to use pegylated interferon based regimens which were effecting in curing 50-70% of people but with really some significant side effects; anemia, mental health issues, extreme fatigue, and the like. And those treatments had to go for long durations, 24-48

weeks. Just in the last year and a half drugs have been licensed which can treat the most common type of Hepatitis C in the country, genotype 1, with one pill a day. It only needs to be 8-12 weeks of treatment for one regimen; 5 pills a day up to 12 weeks for another regimen and with a very, very excellent side effect profile based on the clinical trial data that's available currently. So you have the prospect of now curing over 90% of people who take these medications using these regimens which are much more tolerable for patients and cause much fewer side effects than the ones that they're replacing. Cost is an issue. Some of these regimens have been priced in the eighty to ninety thousand dollars per cure, and just following this in the media, because there are multiple drugs in the market, different payers are leveraging that to drive the price down so there's probably about a 40-50% discount now on some of those medication prices. And that's after, again, only being on the market for really only about a year, and given it took us 5, 7, 8 years to get pricing more accommodating for HIV, I mean I think this has been a big move in a positive direction because obviously the cheaper the drugs the more we're able to provide them to more patients. We work with the Indian Health Service through the HHS Office of the Assistant Secretary of Health. Dr. Howard Koh, who just recently stepped down from that position, developed the first Hepatitis action plan for the U.S. government that outlines different interventions for all types of Hepatitis. You can see them there, I won't read them to you. That was just updated last year for an additional three-year cycle. So some of the work that I was highlighting with the Indian Health Service like the Clinical Decision Tool, it's really made possible or at least facilitated by the development of this plan and the standing viral Hepatitis implementation group that's convened by the Secretary's office periodically with the next meeting in March. They were very interested to see how can we work closely and really develop some demonstration projects for Native Americans. One slide I didn't—I can give you more information about it—I didn't really put in here in the interest of time, was a telemedicine approach to health known as Project ECHO which we set up in Arizona and in Utah guided by the founders of that approach in the University of New Mexico, and Richard Manch from the St. Joseph Health System was the project officer in that and help set up ECHO whereby you link specialists with primary care via tele-medicine so it improves their skill set for managing Hepatitis C and that included Indian Health Service clinics in—is it Tuba City, Arizona? Any Arizonans here? Is that correct? Okay, thank you. And then since then that led to other collaborations in Flagstaff which I've been made aware of by Richard. So we're very excited about that. The other project that we would like to get going frankly is what we call Testing Cure Projects with one...for the Cherokee Nation in Oklahoma. Getting back to Debra's presentation we put out a request for proposals last year for public health authorities to develop coalitions with academic medicine, primary care to increase the number of people tested and linked to quality care and treatment. Got excellence response to that including one from the Cherokee Nation, but as we have to strictly adhere to the evaluations of the evaluation panel, even though we had many highly rated, we only could fund the top three just because of our resources. One that was left on the table so to speak was this one from the Cherokee Nation which also serves the Chickasaws in Oklahoma as I understand it. And in talking to them, we really began to discuss how you could really model elimination of Hepatitis C for the Cherokee nation. It's a fairly geographically—has boundaries, it's a set nation with strict jurisdictional boundaries. It has a single health system with primary care in a hospital for specialists. It has relationships with the local health department and

University of Oklahoma, and the leaders of the Nation were very interested in taking on that challenge. So we're really working with CDC and the CDC foundation to see if this type of project lends itself to a public-private partnership in lieu of public resources for this type of effort. But given the rising incidents, which they also have experienced in Oklahoma in speaking with them, and the prevalence and the opportunities to reverse those with these new treatments, we're very interested to see how we could develop this project and others like it for clinics and public health departments serving American Indian communities. And this just shows you the ECHO project which has been very successful. It's adopted for other disease states, it's used by the U.S. Military, the VA and we were very excited to be able to introduce that into the Indian Health Service clinics in Arizona. We've spoken a little bit about drug use behaviors, I don't think we have to go into that any further until there are questions. So in conclusions, liver disease is a major health disparity for American Indians and Alaska Natives. The population is at increased risk for viral Hepatitis. Through the adoption of Hepatitis A and B vaccine strategies we have made remarkable reductions in morbidity related to those diseases and eliminated that as a health disparity for American Indians and now the current challenge is how do we reduce health disparities related to Hepatitis C both in regards to the incidents, the prevalence and the mortality. Thank you. I will be happy to have questions.

Councilman Chester Antone: Any questions? No questions? Okay, Ramona.

Ramona Antone-Nez: Thank you Chairman Antone and members of the committee. Thank you for your presentation. I am just gonna go back to the Hepatitis B transmission. My question is can it be transmitted through breast milk?

Dr. John Ward: It cannot be transmitted by breast milk, no.

Ramona Antone-Nez: Another question that I have, maybe it's Hepatitis C. Is that the one that could become cancer, liver cancer?

Dr. John Ward: Yes, actually both B and C can cause cancer.

Ramona Antone-Nez: So on the Navajo Nation we have many opened abandoned uranium mines. We have exposure. And one of our leading causes of death is, third is cancer. And there's no clear correlation between exposure to uranium and cancer, but the prevalence of cancer is high, mortality. So I'm just curious, I mean I'm just—because of this information here I'm just curious of the possibility of how Hepatitis B and C may be part of lung cancer as a possible contributing factor to lack of vaccination or delayed screening and then treatment due to the cause—you mentioned eighty to ninety thousand per treatment for cure. I mean is there any studies to that because there's such a high mortality of cancer and then it's not really clear, or I don't have the evidence to show that it could be related to uranium. That's just a probable cause and then this Hepatitis B and C. Thank you.

Dr. John Ward: Liver cancer is one of the few causes of cancer death that's on the increase in the U.S. And that's related to multiple causes but two of the major causes are Hepatitis B and Hepatitis C, so we would have to explore if some of the increases in cancer deaths are related to liver. I'm not aware of any literature that's associated these two viral infections with lung cancer. Hepatitis C can cause certain lymphomas, not Hodgkin's lymphomas, and...so that's another cancer type that I'm aware of. In the report of cancer to the nation that CDC puts together in collaboration with NCI and the American Cancer Society will be highlighting liver cancer for 2015, so it will be an opportunity to shine a light on that cause of cancer but I'm not aware of the other causes of lung cancer for the Navajo Nation.

Robert Foley: Thank you, Mr. Chairman. I'm Robert Foley with the National Indian Health Board and thank you Ms. Abramson. We've been working with her to elevate the attention of visibility that Hepatitis C has been receiving and so she's provided previous testimony so I want to thank her for ceding some time to me to ask a couple of questions. Given that there is a proposed budget increase for 2016, and I know it's proposed, to work on viral hepatitis, I would be curious to know that if some of the plans that you put up in your slides are gonna come to fruition in next year, including specific programs targeting AI/AN communities that will increase linkage to care and close that gap in the continuum, as well as increase access to those medications which are cost prohibited not just for American Indians and Alaska Natives but also for the Indian Health Service that's providing those medications, as well as an education and information campaign that's specifically targeted to American Indians and Alaska Natives who are at higher risk for Hepatitis C and we know that risk factors for Hepatitis C often place those populations outside of those groups that receive normal routine primary care. So I guess it's a three-fold question. I hope you can remember all that Dr. Ward.

Dr. John Ward: It's a memory quiz. As you saw, we at least were—an increase in our budget was proposed and that 31 million actually represents a doubling of our budget, so we have a fairly modest budget as it stands now, and the likelihood of getting that is really unknown. It could be zero to 100%. But we did, as you can see, we did write a justification for that budget increase that's publicly available and we made explicit mention of American Indians having this health disparity which we wanted to—I felt was really important because it would really puts us on record as that we're gonna be prioritizing this health disparity if we do get these resources, or even a portion of them we will do what we can in that regard. And then as we describe there, we are committed to improving the care cascade for populations that are experiencing health disparities and so we've explicitly mentioned American Indians in that so we will be striving to do that in that regard. And we're looking at not just only specific in depth programs of the type that I provided by the Cherokee Nation example but also what we call more systemic changes like working with the Indian Health Service get that Clinical Decision Tool in place, get the provider training in place, and then begin to look at the other barriers to care such as cost. Now CDC does not really have a role in setting drug prices for the country. It's just another part of the health system that does those types of things. What we can do, I think is important, is to show how treatment fits in to a prevention program, preventing transmission as well as averting death- two goals of public health- and the cost effectiveness of those interventions. And so we have several

papers that will be coming out in that regard. And then also developing the surveillance systems. You mentioned surveillance a few moments ago, or collection of strategic data, if you don't like surveillance as a word, but we want to give every state a minimum...an amount of money so they can collect a core set of data to identify incidents, monitor their burden and to track the care cascade that I showed you up there. And so we are committed to doing that, and in so doing would help address these health disparities. I think one area that we can improve upon, I notice that the Navajo's have an epidemiology board and the Indian Health Service has epidemiologic staff that I think we could build stronger ties with going forward and so I think that would be really important to do because I think that would help us develop more appropriate programs, build on capacity that's already there, and get everybody understanding the scope of the problem and more ownership of what can be done about it. So I would look forward to those opportunities going forward.

Robert Foley: I think one recommendation to explore, and you mentioned providing states monies to continue to track or enhance the tracking of Hepatitis C. If you want to build up some of those relationships with tribes and epidemiological centers, you might explore providing funds directly to tribes and tribal epidemiology centers to track Hepatitis C rather than asking tribes to go through their states.

Dr. John Ward: I agree. I recognize these as separate nations and that's why I was very excited about working with the Cherokee Nation as sort of a first step in that direction. I think we would develop more expertise in how to develop those relationships. Cherokee Nation has a problem in its own right but we could begin to scale up from that first demonstration project to build relationships with other American Indian nations that have health systems that have the capacity to work with us. I think it's a very exciting proposition frankly.

Councilman Chester Antone: Are there any other questions? Comments? If not, thank you very much for your presentation.

Dr. John Ward: Thank you, again.

Councilman Chester Antone: We're almost done folks. I wanted to ask Romana to give us an update on this afternoon's proceedings or a wrap-up.

Romanadvoratrelunder Fetherolf: Hi, my name is Romana Fetherolf, I'll be providing the afternoon session summaries. We started out with the NIOSH session. Elizabeth Dalsey discussed the state-based surveillance system and will send information about this grant to TAC members. Secretary Adam Geisler asked about the amount of funding for that grant and Elizabeth Dalsey will follow up. NIOSH also requested feedback from TAC on whether or not a Young Worker curriculum is needed at Indian Country and how it should be tailored. Injury Prevention discussed motor vehicle safety and suicide prevention. Ramona Antone-Nez asked about articles on suicide prevention programs and research, and Commander Crosby said he would be able to share that. We had a discussion on the budget process and proposals for 2016. And Dr. John Ward gave an

overview on Hepatitis C and its connection to drug abuse and briefly mentioned the Project ECHO and starting a project with Cherokee Nation. Have I missed anything?

Secretary Adam Geisler: Maybe I didn't hear it but I wasn't joking about getting a meeting with the heads of the—I realize HHS is the—we call it the big brother but I guess a parent agency. It would be nice to be able to work with leadership from both directly from the CDC and HHS to discuss some of these components because that's what I'm really hoping. Are these serving as minutes? Is that kind of what the summaries act as for these meetings?

Annabelle Allison: They're pieces of them; not completely but we definitely will have a transcript of the meeting with some action items.

Secretary Adam Geisler: Gotcha, okay. Sorry. I don't mean to be nit-picky, but just something I want to make sure was caught. Thank you.

Romanadvoratrelunder Fetherolf: Thank you.

Councilman Chester Antone: Anything to say anyone before we—

CAPT Joe Maloney: Yeah. This is Joe. Just a reminder that tomorrow is supposed to be the best day of the week weather-wise, so if you don't want to walk, the shuttle will still leave tomorrow at 7:15, so for folks staying at the Emory Conference Center that will be 7:15 in the lobby.

Councilman Chester Antone: I believe that dinner is at 5:30. (Inaudible.) It's at the Tin Lizzie which is right over there in that little mall. And that's with the CDC leadership, unfortunately have to pay for your own meal. If there isn't anything else, I'm gonna say the closing prayer before we leave.

Closing Prayer

END.