

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

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CDC Headquarters
Atlanta, Georgia

February 11, 2015

Opening Blessing

Councilman Chester Antone: Good morning everyone. This morning before we start, as is the custom of Native Americans, we do have an opening blessing, which will be provided by Mr. Flying Hawk this morning.

(Prayer)

Councilman Chester Antone: I'm gonna turn it over to Joe; he's got a few items that he needs to let us know.

CAPT Joe Maloney: Thank you, Mr. Chairman. Good morning everyone. Thanks for joining us. Just a few housekeeping items for folks that are new to the meeting today. The closest restrooms are out the door to the left; there's others if you keep going right. In the event of an emergency, we do have a shelter-in-place in this room and in the event that we have to evacuate, we'll go out the double doors and outside. Some quick reminders for the rest of the meeting today, the members of the public do need to sign in at the registration desk and wear your name badge at all times. Non-CDC/ATSDR attendees must be escorted by a CDC employee throughout the building. Just a very important reminder that today, during blessings and during Tribal Testimony, if people will not come in or leave the room during that time. And lastly, a reminder to please silence your electronic devices as we go through the meeting today. Think that will do it, Chairman.

CDC Office of the Director Update

Councilman Chester Antone: Ok, this morning we have the CDC Office of the Director Update and this will be done by Ileana Arias, Principle Deputy Director of CDC/ATSDR.

Dr. Ileana Arias: Thank you and good morning. Welcome to the Tribal Advisory Committee to Atlanta, and on behalf of Dr. Freidan, who unfortunately couldn't be here, he wants to welcome you very warmly and glad that you're here and looking forward to discussions that you'll be having with the rest of the staff throughout- for the rest of the meeting that you have. Unfortunately, because of Ebola and Measles, which I'll talk about in a little bit, he's up in DC involved in hearings and briefings on the Hill and so was called away at the last minute and couldn't join us but he sends his regards and warm welcome. I'd like to also welcome the new TAC member to this meeting and to this work and I also then would like to extend a very warm appreciation and thank you to our Chair and our Co-Chair for their great leadership in the work that has been done, that the TAC has done, and also in collaboration with us. I know that you have met with some folks yesterday, and you're going to meet with a number of folks today to

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talk about some of the things that we can work on together. And Judy is going to also provide an update on some of the activities that I know you're interested in and that influenced the work that you do and the ability to do your job. But what I'd like to do is just sort of give you sort of some updates on a lot of things that we have talked about previously and we had talked about sort of stepping up and following up on. And just to give you a little bit of an idea of how much progress we are making, and although we have significant progress to make I think, we are headed in the right direction. One of the things that, you know, yesterday from talking with Dr. Bauer, is that her Center has made a significant commitment to addressing health disparities and the health needs of American Indians and Alaska Natives. And one of the things that was done this year is put out an FOA that specifically was targeted at Native communities and entities in order to do that work. So that the amount of funding that is now being essentially used to address those issues has increased significantly. She personally is responsible for that; she personally is committed to continuing to do that, but the rest of us are as well and we're very interested in sort of finding all opportunities that are available at our disposal that can be used in order to increase the funding and the resources that are available to you and your colleagues in order to address the health issues that are identified.

In the spirit of that, one of the things that always has been pointed out to us is that in addition to funding, making the data available and improving the data that we have to address- #1 to identify what the health needs are for tribal communities is important and we have committed to doing that. One of the things that we did actually, this was in follow up to a discussion that I was involved in at the Secretary's Tribal Advisory Committee meeting last...I lose track...I think it was in the Spring, was to make sure that we pulled our data and actually we did provide the data that are available that can be used although it may not be targeting that is monitoring specifically in Indian Country or specifically among American Indians and Alaska Natives. One of the things that has been done is call through all of the sources that we have available and identify when it is that those populations and subpopulations are identified and how it is that the data could be used. So we provided the link to those data so that they can be accessed directly and also put together a table that then sort of walk through what the data sources were, what the variables were, and what is it that could be done with that information. We are more than happy to continue to provide that information and any assistance in using those data sets that folks might need and be interested in. The best way of getting that assistance, of course, is to contact Judy's Office, who then will find the appropriate people, whether it's in the program office or in the specific CIOs, to help with that and provide that kind of assistance. Related to that, one of the things that I was very happy to see is, we also released in the MMWR in January, a supplement to the MMWR, an article specifically focusing on Native health disparities and addressing not only shining a light, but then also being a little bit more specific on what are the major problems that need to be addressed. I am committed to making sure that that continues, that we do put out that information on a regular basis; not only for us to be aware and then for the country to be aware at a national level what the problems are, but also so that information can be used in decision making, again, at the national-level and at the local-level in order to address those issues.

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One of the things that we had talked about, and Judy will talk more about this, is PHAP and how is it that we can increase accessibility to the Public Health Associate Program to Native populations and communities. I'm happy to say that we have six PHAPs, or associates, that are actually either assigned to a Native entity, or actually working on Native issues: three in the 2013 class, three in the 2014 class, and we are very interested in continuing to increase that number. I'm happy to say that we're in the process now of reviewing applications not only for the associates, but also for the entities that have applied to have associates, and we have eight applications from tribal entities and organizations in order to...applications for housing those associates. They are currently being reviewed and so we're looking forward to what the outcome of that is.

As you know, there are a number of sort of programmatic issues that have been very prominent in the media and so I just want to touch base where we are on those; just so that you know. And one of those we've already talked about before, unfortunately, because it's been going on for a long time, and that's the Ebola outbreak and the Ebola epidemic. As you know, and we've talked about it before, and as you know from yourself what's being reported in the media, it is a significantly large and taxing issue that we have been working on for a significant period of time; and that we're gonna continue working on for a long time. The epidemic, the outbreak is by no means over and so we have to continue to devote as much fervor and resourcing to the issue as we can, but there is some sort of early signs of success so that we are starting to see stabilization in some of those countries, no new cases. And in other countries, a significant change in how it is that public health entities, the country public health entities are approaching the issue. So there is significant success. We are hoping that it will continue. It has not spread; so Nigeria, Mali were able to now go to zero; and so we're hoping that in the not too distant future, we'll be able to say that about the other countries as well. We continue to deploy significant number of people to those countries in order to do the work that needs to be done to make sure that we get to zero, which is the goal that we have; the goal that we all have. As you know, there were back in November, some cases in the U.S. of Ebola as a result of travelers coming in and then healthcare workers who came in contact with that traveler. We do not- since then, we have not had any other cases, do not have any current symptomatic cases of Ebola in the U.S. and that's good news.

In the context of devoting as much- so much resourcing, including people, to Ebola as we can muster, we also are dealing with flu and within this Measles outbreak. Flu, not surprisingly, it's seasonal flu; it's what we go through every year. Unfortunately, this year we actually had evidence that there was some drifting and sort of some change in the viruses that were prevalent in cases and viruses that had not been included and had not been addressed by the vaccine that was developed to address flu in anticipation of what was going to be circulating. Some of the circulating strains are covered by that vaccine so we are still encouraging individuals to vaccinate against flu because there is some coverage, there will be some effect of the vaccine, but some people will not....essentially, for some people that will not be the case. Again, depending on what strain they actually come in contact with. For individuals who do get sick, we are trying to encourage physicians and other health care workers to use Tamiflu as a way of addressing the

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symptoms and sort of making sure that they control the disease and encourage some relief in those individuals.

The other is then this outbreak of measles that started in Disneyland, and most of the cases, currently we have about 122 cases is the last count that we had. The majority of those, in excess of 90, are in California, and can be tied...and again, most of those can be tied to exposure in Disneyland. Most of the individuals who have developed the disease are individuals who either do not have a history of vaccination or of exposure, and so not surprisingly, they are the ones who are succumbing to those exposures. We are encouraging, even though as you know there are some holdouts, but we are encouraging people to be vaccinated against vaccines, both children and adults if they haven't been just to make sure that they – if they come in contact with somebody that does have measles that they don't contract it. Yesterday, we also contacted the WHO and provided sort of a what we called an emergency of international concern or potential concern in that since there is one case in Mexico now of measles and it can be traced to the Disneyland exposure. We are concerned that there may be some individuals who were in Disneyland at that time and traveled back to other countries and may be exposing other folks, and then vice versa; that people may be traveling here. So we want to make sure that people in other countries are aware, and when there are measles cases, that they actually do the right kind of questioning and investigation so that we can get a better idea of the complete spread and extent of the problem. There has been a lot of attention to the issue, and personally I think, not so much because of the numbers or the severity of the disease, but because of the reason we've had the outbreak and that is significant number of parents continuing to suspect that the vaccine is dangerous, that it's not safe, which in fact the data have never supported that. However, they continue to be a significant number of holdouts that are concerned about exposing their children to the vaccine because of potential cognitive problems and other kind of problems that erroneously have been linked to those vaccines. We have, and others have, been very clear about the safety of those vaccines and that not being a reason for not vaccinating children. So we're continuing to encourage that because of that controversy, it's gotten a lot of attention in the media. One of the things that I'm happy to say is that coverage among tribal communities for measles vaccine is very high and so that's very good. And so congratulations on that achievement and we thank you for partnership in making sure that that does happen. So, that's just a snapshot of what we're currently dealing with. It's not necessarily what I think you are most interested in talking about, I think, but if there's anything that you want to know about that I didn't address or any questions about any of the things that I said, I'd be more than happy to answer those.

Councilman Chester Antone: I think, before you go, we have about 15 minutes of this time. Go ahead, Jefferson.

Lt. Governor Jefferson Keel: I have a question. In speaking about the measles outbreak and realizing that you know at one time we thought it was completely eradicated; and now it's resurfaced, it's reappeared; the international travel that you're talking about, that you mentioned, is it not true that the visitors to the United States are supposed to be vaccinated or not?

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Dr. Ileana Arias: I'm not sure about that. I don't think that we require that; I can look into it and let you know. I know that as with TB and with measles a lot of the times the outbreaks can be traced to imported cases of measles where the vaccination rates in some countries are not as high as they are here in the United States, or even in other countries, for example, that have even higher rates than we do, like in Europe. So some of those cases, some of those outbreaks are the result of imported cases of measles; of individuals who have not been inoculated and then they actually do develop disease and bring it in. When then its people here who have not been vaccinated are exposed, then they're gonna contract the disease and so that is a problem.

Lt. Governor Jefferson Keel: Well, take that one step further, is it not still required that all of our children be vaccinated?

Dr. Ileana Arias: It's recommended, the requirements to...it's recommended that they are after the age of one, or when they turn one. There is not a federal requirement for that to happen, and so a lot of it is done at the local level. Some states are more aggressive in requiring that, whether it's for school entry than others and some are not. Then there's also, even when it is required, there are waivers that are provided for a number of different reasons; mostly because of medical reasons. So high risk kids, for example, should not get vaccinated or have to be careful in how that's done, But that has been used to then get waivers on other grounds and some states are more lax, or I should say, more flexible in how it is that they approve those waivers than others have been, which is why then that you get a difference in terms of inoculation rates across the country.

Councilman Chester Antone: Mr. Geisler.

Secretary Adam Geisler: Good morning. I want to thank you for your update that you provided to the TAC this morning. I had a couple of questions. You went through quite a bit of information. So the first question that I have is in relationship to access to data that you had discussed, and that we need to be working through, specifically Dr. Monroe, in order to access that data. Did I hear you correctly?

Dr. Ileana Arias: Not to access them necessarily, but for technical assistance in how to manage the data, if you will, that's there and what's there and that sort of thing. So we have data sets that are just public access, those are available so we can send, the- sort of links, to those data sets. You can go in yourself. Sometimes, depending on how the data sets are set up, you may need some kind of, you know, additional information in terms of how to identify, how to pull variables, how to sort through the data in order to get the numbers that you actually want. And so that's the kind of technical assistance that I was referring to is if it's needed that the best way to get to that is through Dr. Monroe's Office.

Secretary Adam Geisler: My second question for you, I have three- the last one, I think, is probably low hanging fruit. The second question that I have for you is in regards to where the

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Director stands in relationship to specifically funding some of these activities. Yesterday we had a pretty significant discussion about surveillance, and I think the need to be able to properly implement those activities within our own centers. And so, I guess, you mentioned at the beginning that Dr. Bauer has kind of led the way, in the way that she's approached this; does the Director support that activity with the other Centers? And I guess what I'm getting to is the dollar.

Dr. Ileana Arias: Yeah. No, for sure he does support it. And not only does he support it, a lot of our programs are interested in making sure that that happens. As you know, a lot of that, unfortunately comes from the top; so in terms of setting aside funds specifically for addressing these issues, a lot of times we don't have the ability to do that, legally to do that, so it means getting Congress to essentially direct us to do that which is what happened in the case of Chronic, where there was specific mention in the Congressional record about using monies for tribal issue. So that makes it a lot easier for us to be able to then specifically and very directly set aside funds or direct funding specifically to that. In the absence of that, what we then try to do is, for whatever project is being done, is there a specific disparity that is relevant to tribal communities; and if so, then how is it that that can be addressed? It doesn't necessarily mean that the funding would go to tribal entities for doing that work, but if it does go to a state, organization, or a community based organization, how is it that we can either set up the FOA, set up the funding, or work with them in order to make sure that those populations are well represented.

Secretary Adam Geisler: I appreciate the legal constraints that are associated with legislation that comes down and the way funds are appropriated, but at the same time, we also had a conversation yesterday regarding the development of the internal budget that's recommended. And I guess, what I put forward, and I apologize I do not remember her name, who sat here and went through the budget process. Deb?

Dr. Ileana Arias: Deb Lubar.

Secretary Adam Geisler: Yeah. One of the comments that I made to her yesterday, and I'll make it directly to you, is that I think that in Indian Country, there's – we've always- we're always told, "You need to go to Congress. You need to go to Congress. You need to go to Congress." But at the same time, I think if you're seeing the need internally in the budget that you are creating and recommending, one of the things that can really help us out, so that we're working together in partnership to solve the bigger issues that are out there, is the recommendation internally coming from the Director himself or from within the Centers.

Dr. Ileana Arias: I mean I think that, and we've gone through this with other issues and other communities as well. My, and I don't know if this was discussed yesterday, but my sort of take away of what works is to focus it is as much as possible. You know, we do rely on Congress to sort of allocate resourcing generally and then specifically to us. If it's very broad, it gets lost. And so one of the things that might be worth thinking about is whether in response to what was published in the MMWR about what those inequities are; or regardless of that, whatever issues it is that your organization, the tribal entities are interested in addressing and then being specific

about that as opposed to funding tribal entities. That a lot of the times works a little bit better because then you are relying on two types of champions, if you will, on the Hill to get those folks who are interested in supporting tribal entities and folks who are specifically interested in that whether it is diabetes or cardiovascular disease; whatever the case may be. It also, you know, by starting and sort of focusing on a particular issue I think also is a foot in the door; and once you get a few of those, then you don't have to fight the fight as much about the tribal entity issue. You can then branch out from that. So one of the things that might be good, whether it's here during this meeting, or off, you know, in-between meetings to sort of start having that discussion about what are the issues that are relevant, that we know that something can be done, and that there would be champions for supporting and resourcing addressing that issue.

Secretary Adam Geisler: I think the challenge in that, and I apologize I don't mean to take up too much time, but I think the challenge in what you just went through is that we have a hard time identifying those situations because we don't have the funding to do the surveillance in order to reach those conclusions that this is what we need. So that's the challenge that we're always facing in Indian Country, and it's not just here; we realize everything is data driven in order to make the ask right? In order to get there, a lot of times we don't have the financial well-being in order to get to that place. And I'll take it one step further in terms of tribal entities, you know, we're tribal governments and the relationship that we have with the United States is unique in its political nature. We're not just an ethnic group out there. You know, it is a political stature that we hold in the United States Government. So I just wanted to put that out there. I understand what you're saying but I hope you understand where I'm coming from with it's hard to get the data if we don't have the money to do the analysis.

Dr. Ileana Arias: Right and I know that, you know, it makes sense to sort of focus on the immediate sort of community that you want to address, but we do have national data and that national data can be used. We're trying to sort of make it more easily accessible, more easily digestible, if you will, so that it can be used to answer those questions. And so having the discussions about what is missing from the data that we are putting out to be able to make those kinds of decisions or to encourage others to have those kinds of decisions would be discussions that we should be having.

Secretary Adam Geisler: Ok. My last question was what is the PHAP? You said there was three-2013 individuals, and three-2014.

Dr. Ileana Arias: So that's the Public Health Associate Program and these are currently trainees that we have so the public, are you familiar with the program?

Secretary Adam Geisler: That's why I am asking.

Dr. Ileana Arias: Ok. So Judy will talk more. It is the centerpiece of what we've been trying to do, which is essentially train a workforce that is going to be relevant and available, not for CDC, it's not training people for us, but for public health. And the way that the program works is it's a competitive program for bachelors-levels and masters-levels individuals who are interested in

public health. They are in the program for two years. We're changing it to maybe extending it, Judy might be talking about that a little bit more. The idea is that they get trained, they actually get placed in the State Health Department during those two years to basically do the public health work. We have been talking then about, not just in State health departments, but also putting them in Tribal health departments and so, how is it that we make that happen?

Councilman Chester Antone: We just have one more and I'll defer to Mr. Keel and then we'll end this part. Cathy?

Tribal Board Member Cathy Abramson: How can we seek the support of the Director to consider broadly assigning CDC field staff into Indian Country?

Dr. Ileana Arias: I don't know, I mean he's interested in just field staff generally. I think we have to have the discussions about, again, given the legal issues and sort of the other issues, how is it that we make that happen? We have been focusing on PHAP because that's what we have the resources for, and that's what we think actually adds the most value to whatever entity that we actually do place people in. But we can then also explore, and Dr. Monroe's Office also does work on sort of field staff generally. So we do it from the OD; we also do it from the program-level.

CDC Office for State, Tribal, Local, and Territorial Support Update

Councilman Chester Antone: Well thank you, Dr. Arias. We'll let you go for this time and we'll switch over to Judith. Thank you.

Dr. Judith Monroe: Ok well thank you, Dr. Arias. Thank you Chairman Antone and Co-Chair Keel. Great to have all of you again with us so good morning. I don't have any slides so I would like to make this as interactive as possible and so that we can have a discussion. I know we have new members on the TAC so I'm gonna go back, as I discuss the update for OSTLTS, I will give some background- broader background that some of you may already know about. So just for ground leveling, when Dr. Frieden became the director of CDC, he felt that the agency needed to better support our health departments, and so OSTLTS was created in that spirit, and this really goes back to the history of CDC, back in the 1940's when CDC was first established. It was established because of malaria in the south and it was specifically established to help support health departments that were battling malaria. And so this really is at the root of, you know, CDC. And so OSTLTS was created; we're right at our five-year mark. We've been part of the Agency structure now for a full five years and we're unique in that we're a cross-cutting Office so we're very broad, we're very cross-cutting unlike, you know, when you'll hear from Dr. Bauer, as an example, they dive very deeply into chronic disease and then very specifically into the particular diseases so whether it's diabetes or heart disease and so forth or whether like Hepatitis C you heard from yesterday; a very deep dive into those specific diseases. We're very cross-cutting. I report to Dr. Frieden. I'm one of his direct reports, one of the Deputy Directors for the Agency. And so we, in many ways, have a bird's eye view of the Agency because we were established with

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an eye towards supporting our state, tribal, local, and territorial health departments and communities; but to do that, we also are in a position to support our centers, institutes, and offices across CDC.

So I'm happy to say that at a five-year mark, I think we've pretty much touched the entire agency one way or another. And much of that foundation of our office is communications. It's something; I came in, having been a State Health Officer in Indiana, I really grew to appreciate the value of communications. And so we've built a pretty robust communications group within OSTLTS. I have a number of communication products, but we built those with an eye toward getting information out of CDC; and we really serve the CIOs. I mean we're here to serve and to reach the health departments; the STLT is what we call it. We also, in turn, have built communication products so that the field can communicate inside CDC. And so we really do serve as your, and I invite you to use us that way. I think there's still a lot of room for advancement and growth as we continue to mature as an Office. One of the things, look to us as your touch point, and then we will reach across CDC or get messages out and then try to get messages out to you. So as an example, of just going with Ebola, we're not Ebola experts within OSTLTS; we're not infectious disease but we got called upon just like the entire Agency for the Ebola response. And so we did things like, you know, Joe yesterday talked about the reach to the Indian Health Service; and what we'll do is find the experts at CDC and make sure we match up with where the need is. One of the things that came out of that, there was a Dear Tribal Leader letter about Ebola after Dr. Freiden visited Africa. That was something our Office helped facilitate because we saw the need. In fact, I talked to NIHB at a meeting and asked their advice whether that would be a good idea and they said, "Absolutely." And so if you all just with the communication piece, if you see areas that you think we should be doing more Dear Tribal Leader letters from Dr. Freiden, please let us know. I would appreciate our TAC members giving us ideas for that because then we can then facilitate and make that happen; and so in many ways we are a facilitator. You know in my role for Ebola, as an example, I got called in to, I was actually full time on Ebola starting in October for several weeks just because there was so much demand and need once it became a domestic issue. You know, once we had the case in Dallas, the health departments, as you can imagine, in all the states in all the issues that would come up because we have existing and established relationships and ongoing communication channels with our partners out in the field. We're a natural place then for the programs to come to so that we can help assist. One of the things we have said before is that we don't make the ball, but we make the ball bounce higher. So we're really here to try to facilitate.

There are kind of three areas that we focus on to categorize our work. One is with performance improvement and setting national standards. The second is with technical assistance as you heard Dr. Arias mention, and then the third area is workforce. So I'll touch on each of those as I give the update on what OSTLTS has been doing. I do want to draw you all's attention to the fact that we have- Dr. Freiden established an Advisory Committee to the Director and there are a number of members of that ACD, and they meet twice a year in the spring and in the fall, and they bring formal recommendations that are public records so you can go out and find these easily. They're on our website, you can look at past minutes; everything- the meetings are all in

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the federal register and announcements and so forth so it's all a matter of public record. And there are only a couple of subcommittees, and because Dr. Freiden feels so strongly about our support to the field, we have a STLT subcommittee. So I'm the designated Federal Official for that. We have a state, tribal, local, and territorial subcommittee to this ACD, the Advisory Committee to the Director. It's been in existence about four and a half years now; we started it pretty soon after OSTLTS was established. Just to give you historically, that body, one of the things they made was a series of recommendations that went to the ACD that resulted in a standardized funding opportunity announcement here at CDC. And this is very important I think, especially for the new members to understand. It's the first time CDC had ever had a standard format for funding opportunities and with it is a checklist; and that checklist gets updated every year. And so you heard yesterday, I think when Dr. Ward was speaking, Ursula Bauer and some of them, and even this morning with Dr. Arias, Congressional intent comes down and there's particular language in our appropriations. And so if those appropriations specifically say American Indian/Alaska Native then you can be sure that that funding opportunity is going to have that opportunity in there. Other times, the language it may not specify, and then we have to work a little harder to find out whether it's allowable. What we've done with our funding opportunity announcement, because of the standard checklist, no one across CDC can begin the process of writing an FOA without going through this standard checklist. And on that checklist, everybody has to stop and look at the language because the standard FOA requires the broadest, eligible grantees if you will. So everybody has to stop and think about it whether or not it's allowable; and a lot of that was voices from our colleagues that are American Indian and Alaska Native colleagues that sat on the STLT subcommittee that raised that as an issue. So those are...that's one thing that we've done historically and that's been in place now two or three years.

Most recently, the STLT subcommittee raised recommendations that went to the ACD and were just approved by the Advisory Committee to the Director on three different categories. One were foundational capabilities of health departments. And there's a big body of work that's been done now looking at the foundational capabilities of what every health departments should be able to do. And that goes- it's really complimentary to accreditation of health departments. That's a whole talk in and of itself. A second set recommendations around social determinants of health, which certainly are very important to Indian Country. And then, some recommendations around the Block Grant. So you heard yesterday I think mentioned in the President's budget that it's been zeroed out. Every year, the Preventive Services Block Grant, which is the most flexible funding that goes to state health departments; every year it gets zeroed out of the President's budget. It doesn't matter, it's always zeroed out. Congress tends to put it back in and this past year it was actually brought back up. It had been cut quite a bit but it was brought back up to a level that it had been having—so about 160 million dollars for the Block Grant. It's flex money, Congressional language, the appropriations; that goes to state health departments. It's very specific to that states but it's flexible. So, to give you an example, and one of the things that we do in our – in OSTLTS, is we do try to be the voice when we're working with our colleagues in states and locals and the longer we have matured, I think, as an Office I think we've gotten better at making sure that we're bring up...at asking questions about tribes. So, as an example with the Block Grant, and I don't know in how many states if any of the Block Grant funding gets to the tribes, but as

one example the Kickapoo Boys and Girls Club had an after school activities program, so this will be in Kansas, and they had physical activity, they had sports and games and cultural activities; but their attendance was dropping off and they were – they needed some support. It was a very rural location and so the club partnered with two local school districts, got a loaned bus to increase attendance and to make sure the children were able to go into this program. But they were able to do that because they were given some of the Block Grant funds. So the state must have given Block Grant funds to the tribes to be able to do this and they were able to hire staff then to accommodate the increase in the children that were now getting the physical activity and the cultural activities; it sounds like a great program when you read about it. And so that's just one example because it does- with funding it gets complicated because there are so many different streams of funding and where the opportunities might be.

One of the things we've heard loud and clear is that it varies across the states how tribal governments work with state government. And that's an area that we have actually worked with NIHB and with our Association of State and Territorial Health Officials to try to—actually both of them wrote primers on how to work with governments. So new state health officials today, and this is something that came out of OSTLTS and then our partnerships; today if a new state health official starts, the ASTHO sends them how to work with tribal governments. I will tell you, when it comes to state health officers, we have about half of them are brand new because of the election in the fall with new governors. We have about...yeah, so these are brand new people. They've maybe not ever been in government before or they've been in other walks of government so they will get that. And then the flip of that is folks coming in and leading tribal public health or getting, I believe NIHB then puts out... has a primer that ASTHO helped write, "How to work with your state government." So trying to build that type of communication. So to just give you a flavor of some of the kind of work that we do.

The other area I mentioned, standards and accreditation, we're the Office here at CDC that supports the National Accreditation of health departments. We do that by supporting our Public Health Accreditation Board or PHAB, and funding- we have some funding that goes to PHAB then; but we also participate in a number of meetings. CDC plus PHAB established the Tribal Standards Work Group that has guided the standards, development, measures, and documentation guidance for tribal health departments. Joe, I believe you've been involved with PHAB? We have members actually around the table that have been involved in some of the...Ramona, I failed to mention, is a new member to our STLT subcommittee; and so we've got some cross-fertilization, if you will, between our TAC and some of these other opportunities. And so they've- the tribal representatives on PHAB's Board of Directors have been very involved in numerous work groups and committees to support the continuous improvement in this accreditation. So since 2012, when accreditation launched, there have been two tribal health departments that have applied for accreditation. But the new and exciting thing that we did, and actually through conversations with National Indian Health Board, we realized that we should seize an opportunity to better fund tribes to help directly to help them prepare for accreditation. So in 2015, and it was just announced, NIHB just announced this, we were able to fund NIHB and they've been able to have the Tribal Accreditation Support Initiative, where there have been a number of tribes. Let's see I

think there were five tribes that received some direct funding to be able to help them achieve accreditation. And they're varying sizes, they're from Wisconsin to Washington State, Michigan, North Carolina, they're across the country. The funding was \$10,500.00 per tribe so it's not a lot of money in the scheme of things; huge, but it does go a long ways for this type of work and to be able to do this. So each of the tribes is constructing an individual work plan to accomplish specific, concrete steps toward achieving at least one or more of the PHAB standards. So we've been very excited about that; and that targeted funding is something that we've got an eye on, you know; how do we do that to achieve the goals. One of the things, because our office has – because we're crosscutting and because we've done a lot around performance improvement, just to let you know, Craig Thomas, our Division Director for our Division of Public Health Performance Improvement, actually is on international travel. Global Health, invited him to give a presentation. I just got a note from him yesterday. He gave a presentation in Paris to a European Delegation around performance improvement, standards, and accreditation; and then he is leaving there going to India for a big meeting in India. And so Global, from an international perspective, folks are very interested in the system's approach and setting standards and how do you build relationships so that you can get things done. So we're very proud of Craig and that request that came from Global. So that's our accreditation work. The other thing with Performance Improvement, this program now has ended; the funding- we only had the funding for four years but we had funding through the Prevention and Public Health Fund that we were able, out of our Office put over nine and a half million dollars went into tribal governments that actually reached about 250 of our federally recognized tribes. It was the National Public Health Improvement Initiative, NPHII is what we called it. It really was to help advance standards and performance. So to give you an example of some of the things that it helped advance, the Alaska Native Tribal Health Consortium more than doubled, they looked specifically at tobacco cessation; and they more than doubled the percent of their patients in pulmonary and cardiac clinics that were smokers, those that were being referred for smoking cessation. So it was a very nice increase in that and that was a process improvement and we look at things through our Office as, what are the systems and how do you do something...tweak something in the system to improve and move everything forward. Cherokee Nation used NPHII fundings and they were able to write their first Tribal Public Health code. In Arizona, Gila River, is it Gee-ia? Gila River Indian community—okay, Gila with an "H". Sorry about that. They worked on Medical Electronic Disease Surveillance and built an integrated system that better protects patient information. So it's really wide ranging the types of projects that people use, you know, the tribes use the funding for. Other examples were improvement in tribal emergency planning for heat emergencies. Some of the tribes looked at that. We had the Montana-Wyoming Tribal Leaders Council supported efforts to identify public health gaps among member tribes and gave out mini grants; so they received funding and then from there, they gave out the mini grants to the tribes to be able to conduct health assessment using the National Public Health Performance standards and the Mobilizing for Action through Planning and Partnerships, or the MAPP process that has been around. So we have a number of examples that we've been very happy about in OSTLTS, and would love to- of course we would love to have more funding to be able to put out for those types of activities.

In terms of- the other thing that is within OSTLTS is Public Health Law, and I invite all of you to- if you have questions or need technical assistance, our Public Health Law Program stands ready to help. They've already done a number of different projects and provided technical assistance to tribes on Public Health Law issues, and they do a number- they have a Public Health Law Tribal Public Health page on their website so we'll make sure we get that out to all of you because that would be a page you could go to that's specific to those laws that would impact the tribes. A new body of work that we're really excited about that they're doing is the Tribal Epidemiology Centers as designated public health authorities and we think there is great opportunity with the Tribal Epi Centers being public health authorities. There was some technical assistance, questions that came to our Public Health Law Program so in response to that, they've created an issue brief to really walk folks through, and they've done this with a cooperative agreement with the Association of American Indian Physicians, AAIP, to summarize the Affordable Care Act's Tribal Epidemiology Center provisions. And you heard from Ursula Bauer that, you know, she has funded all of the Tribal Epi Centers through some of the funds she was able to mobilize; so we're very excited about that. This publication, this memo will be coming out at the end of the month or early next month, in just the next few weeks.

Workforce, I said was one of the three areas. We have the Accreditation and Performance Improvement, technical assistance that we offer, and then workforce. So to talk a little bit more about the Public Health Associate Program; Dr. Arias did a nice job of describing that program. For the new members, this is a program that had started but it was just a very pilot program prior to 2010. And then OSTLTS was established, and Dr. Freiden said, "I think this is a program you guys need to really build." And so we have every year increased the number. Our ultimate goal is to have 200 per class and the classes, they're in training for two years. So when we reach our stretch goal, hopefully that will be the – hopefully Dr. Freiden will be happy when we reach that number because he keeps increasing the number for us, but that would be a total of 400 folks that have bachelors or masters degrees; and about a third come in with master-level degrees that are CDC employees. We've hired them, they have training here, so we offer classes, we have ongoing – you know, we have a whole curriculum that has been established, continues to be improved upon, but they are placed in health departments. But we've gone beyond that. We now are allowing applications from other organizations like 501C3s and so forth; so we've broadened that because we've increased the number. Now, I know from our Summer TAC, we talked about this, and we've talked about trying to place more associates in either tribal serving organizations or tribes. We're committed to doing that and I've talked with our staff about it because I do understand that there have been applications, some very good applications applying and then they didn't-from tribal organizations- that did not receive a PHAP, weren't actually placed. There was a matching, we obviously have to match, because we don't want to send you someone that doesn't want to be there or wouldn't be a good match so that it gets, there's some complexity behind the scenes here. But I've talked to staff about making sure that we're pulling out those applications that come from our tribes and we're gonna work harder at trying to increase the number; especially with the increasing number in PHAP. At this point, we have...Ileana was giving you the numbers in terms of how many are actually there now. We have six associates currently with tribal-related assignments but I would love to see more of those. And then the flip of that is

that we would like to have more applications from individuals that are from tribes that would like to come into the program; so there's two opportunities here both to have trainees and then also to have placements. It's been high growth; it's the type of program we've had to continue to do a lot of improvement on and we welcome your input on maybe how to go about doing this even better; but we are committed to having more placements. I will tell you, the public health associates, it's just amazing the capacity that they've helped us increase. I don't know if mentioned this, with Ebola, we've had over 50 of the associates I believe that have stepped up, went to quarantine stations, and went into health departments. So we have a workforce that's in training, but then something like Ebola hits that's a threat to the whole world and we can mobilized quickly and it gives them great training experience, if you will. So we've been very pleased with that.

Sam Taveras, I see Sam sitting here, Sam oversees our national partners. And we have- OSTLTS has, how many now, 24, 25? Twenty-five national partners that we manage the cooperative agreement. Two of those, we have the National Indian Health Board and the Association of American Indian Physicians, are two grantees right now that are focused obviously on tribes. And Sam and his shop, my hats off to the hard work there that's been done because he's built an opportunity for CDC where we manage the cooperative agreement; but then the CIOs, it's a mechanism for them when they have funding or special projects, they can come through that mechanism to get the money out to the partners very efficiently to get the work done. And so it's, I don't know, hundreds of projects that are happening because of this mechanism. And it continues to be again, it's another opportunity for tribes that we probably should continue to explore more opportunities. I don't know if Ursula mentioned this yesterday, but sometimes there is year-end funding; on the front-end we're trying to establish budgets and put money forward. On the back-end, there's year end funding sometimes and this mechanism. I know Sam works very hard at the end of the year because folks want to put year-end funding in through the partners. But another opportunity, especially I think going back to what Dr. Arias said, if the TAC comes to us with specific areas that you'd want us to focus on, then we make sure that's communicated throughout CDC and then sometimes opportunities come up that are short time lines; we can move quicker perhaps to make things happen, we would welcome that conversation.

And then we're certainly changing, no I won't end here because I've got a few more things. I didn't think I'd take up all my time but I may. There's a lot to report out. But as OSTLTS has continued to grow and develop, now we have Annabelle Allison, as you heard yesterday, and so that's, I think, a big change because when we had really the visibility now of environmental health and associated tribal work can be even broader because with Annabelle in OSTLTS, I mean, this really was the National Center for Environmental Health, in the Agency for Toxic Substances and Disease Registry's tribal affairs activities coming over to OSTLTS. And it gives Annabelle the opportunity then to have broader audiences and to do broader public health but with her expertise in environmental health so we're excited about that. A few other things with- just a few last comments and then we'll open up for questions and whatever y'all would like to advise me on as the Director of OSTLTS.

With our partnerships, I wanted to mention through AAIP and work with Professor June Strickland at the University of Washington, one of the activities they do is they conduct Tribal Grant Writing Trainings; and so if folks want to know more about that, Delight Satter can give you more information or AAIP for the details on that. So that's another way that we're approaching this work. I was asked last night what I do, what's my portfolio? And one of the areas that has become a really big part of our portfolio is the fact that the Centers for Medicare and Medicaid Services, CMS, established The Innovation Center, CMMI. And CMMI got 10 billion dollars to innovate across the country, and about two years ago; yeah it was actually two years ago this month that they awarded the first State Innovation Model Initiative awards and they just did their second round of funding; and so we now have 38 entities. It's states, D.C., territory; there's a territory or two in there that have been funded. There are 38 grantees now receiving funding from The Innovation Center. For the states, this funding goes through the Governor's office. What we've learned, is Oklahoma, I believe, really stands out as a state, that as they are doing their SIM work, my understanding from Terry Cline, the Health Officer there, is that tribal leaders are at the table in a very meaningful way. With OSTLTS, when we hear those types of things, that's the type of message that we will try to carry to other states as well; that look to the example of Oklahoma, because when you're doing your SIM work, where are your tribes. Because this impacts Medicaid, it's gonna impact all funders. At the end of the day, we're really at a point in our country where they are trying to move to value based purchasing, and away from paying to do things to people to try to keep them healthy. And every state, anyone receiving this funding has to have a State Population Health Improvement Plan and that requires everyone at the table; and so we want to make sure the tribes are at the table for that because this is an opportunity that's come along. With that, the work that we are doing with the states, and I'm getting a lot of calls now from states to give technical assistance as they now are developing these plans. We work very closely with Chronic, Ursula Bauer's shop is really big in this. The plans have to address at a minimum diabetes, obesity, and smoking tobacco. So those three things are kind of a floor, and then the states can have other population health approaches that they would want to have. Just to give you an example, the state of New York had the largest award and that was 100 million dollars to do this work over the next three to four years. So there's some substantial funding that's gone in to help the system change so pay attention to what's happening in your state and whether your state receives some funding. And then John Auerbach is working with Medicaid programs. He is reaching out to the Medicaid programs; he's our Associate Director for Policy here at CDC and we're working very closely with his Office. But really, we're trying to reach across all the programs with this transformative work. And then lastly, some of the new work that we've been asked to do in OSTLTS is to take on rural health. So we're now the point of contact for the Agency for Rural Health and the White House has some initiatives around rural health. And if you look at the President's budget, he actually has in there 20 million dollars to support demonstration projects aimed at really combatting- having strategies to combat rural child poverty and that includes American Indian Alaska Native; so they've included that. I'm on a call, I think, tomorrow to learn more about this; but OSTLTS, again, is the Office that will help on behalf of CDC to understand what this work is about. We've been the Office to help with something called "Strong City, Strong Communities." So anyway, the rural focus is somewhat new but I think,

16 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."

especially with this White House initiative, that's something new and evolving and we'll see where that goes. So let me end there and certainly open to feedback, comments, and questions.

Joe Finkbonner: Dr. Monroe. No questions, just want to tip my hat and thank you for all the work that you're doing in trying to engage tribes more interactively with CDC. It's been apparent at least through yesterday and today that you and Dr. Bauer have really stepped up in trying to include tribes and getting additional resources and I applaud you for that. And I hope that as your colleagues show up around the table that we have a chance to have some discussions about how they can become more engaged with tribes. And my thought and concern, when there's always an Office that deals specifically with tribes or Indians, is that they become the go to place to deal with all problems that are tribes or Indian, and instead there's supposed to be that Office that then is the conduit to help them understand how to work with tribes and Indians and I hope that by the end of today, get that message across to them that you are that conduit that helps them to more effectively work with tribes so thank you.

Dr. Judith Monroe: Thank you. I can't say enough about Ursula Bauer. She's been a great colleague and it's really been a big help absolutely. But Ileana Arias has really stepped up as well in the OD; she's a real champion as well. And so we begin to see this, you know, you get the leadership that begins to filter out. And I was happy yesterday with the Hepatitis C discussion. When they asked for more funding, they called out the disparity. So if all the programs would begin to do that that takes us a long ways.

Lt. Governor Jefferson Keel: Go ahead Cathy.

Tribal Board Member Cathy Abramson: I too just want to thank you for all the work in bringing us all together. I've just seen great improvements each time that we meet and I'm really impressed with that and let everybody know that. I like what you were just letting us know. And is there a way that you could, for each state, let us know what funding that they do get that we can talk to our state reps about and let them know that we know?

Dr. Judith Monroe: Yeah, actually I think Georgia Moore-, Georgia is still here. We have a funding tool; we do track that and so that would be, what we can do is package that probably, communicate that probably a little differently and package that in a way that you all have that; because we have the information.

Tribal Board Member Cathy Abramson: Ok, because I'm from Michigan and there is no really consultation in the, I don't know. Right now I'm missing a meeting with some of the state liaisons, but it's probably best that I'm not there because, an example is when some of the people that work for the state of Michigan say, "Well, we have to deal with you." And, you know, these are attorneys and so I have a problem with that. But there are new people, as you said, and I just want to be able to know what's available, the tribes...you know, funding sources that the tribes can be included in and applied for and we'll go after those as we go and improve our communications and relationships with the state.

Dr. Judith Monroe: One of the things, Cathy, that's happened is that as we've continued to mature in our work here. ASTHO, I think, they're communicating differently to the new State Health Officers as well around tribal health and the fact that they should have consultation and so forth. So it's- the work gets complicated but there are multiple avenues to carry the message and so through our other partners, no, I think we've seen a big change.

Secretary Adam Geisler: Just one. It is just one. As everybody said, it's impressive to see what your Office is doing; it's been evident over the last day, two days to see the progress. And I do want to commend you because in working with other Agencies, you are a lot further along than a number of them that are out there in terms of the way you're engaging tribes. Even the way that this session has been organized the last two days so I do want to commend you on that. With regards to the workforce component that you had discussed; tribes are spending a lot of time focusing on the employment future for our tribal members or citizens of our Nations; and I guess I'd really like to find out more about the program and it sounds like it's been discussed in the past probably quite a bit. The new guy doesn't know it yet. But, I would love to get the information if that could be disseminated out because there's a big push I know in our area especially with the Medical and Research Centers that are in San Diego, such as Scripps, UCSD, etc., that we've been pushing for that. And with the PHAP, the Public Health Associate Program, so now I understand what the three- 2013 and three- 2014; so are those specific to Indian Country that are out there being deployed in Indian Country currently?

Dr. Judith Monroe: So, yeah. She was talking about the year that the classes came in, the 2013/2014. And so there's six right now that are specific to tribes but what I'd like to do is carve out...—well 200 would be the total class, so there would be 400 total. But yeah, I mean feel free to advise us how many of those 400 should be in Indian Country. We'll take a number.

Ramona Antone-Nez: Good morning members of the TAC and thank you to CDC. Thank you TAC members and CDC representatives. I'd like to also say thank you to Dr. Monroe for your leadership and to your support staff. Support staff always helps the leadership look really good so thank you. There's three things that I'd like to just acknowledge. Number one is that the Tribal Epi Centers are Public Health Authorities. We'd like to thank you for that recognition because it is very important that we continue to have access to data and quality data. We'll work on that and classifications, race classifications, etc. But to have access to that is very important. In that, I'd like to make a recommendation that we continue to have access to and make recommendations for assignments of Career Epidemiology Field Officers to Indian Country. We've made that request and I'd like to make that recommendation to your Office. If you could start helping us to make that a reality because that would really help in the link of data, to monitoring our health status, as well as, I will lead to the next is budgeting and health priorities for the Field Officers. The second is about funding. I would like to see that the TAC start to move towards generating a budget priority in terms of what our health is here in Indian Country. We've had some discussion on that yesterday, and I hear the report....I heard the report that these are CDC priorities. My question to that is what did the TAC, CDC TAC, contribute and how did we

contribute to those priorities? I'd like to see that we become more involved in recommendations. So that would move to act, the CDC TAC to identify what that looks like here in Indian Country. So in the line of budget, I will continue to advocate and request for direct funding to tribes. Although we are working towards improving our relationship with the state health departments who do receive funding, that's always gonna be there and some tribes have better relationship than others. It's also a step towards recognition of that government-to-government relationship that the federal CDC agent has to our sovereign nations. So I'll continue to advocate for direct funding. The third is I'd like to thank you. With how it all happened I don't know, behind the scenes, perhaps it was support staff; don't know and then of course leadership, that ATSDR is now recognized at this table in terms of the work that has been done and to have that be here and having Ms. Allison here to really start working towards what environmental health and impact in public health as it relates to health status; and all the possible environmental injustices that do exist and the need for the responsibility of both federal and tribal, local, state to address these environmental issues that are ailing our, or lifting our health. So those are the items that I'd like to bring forward and also call to action the CDC TAC. I address that to the Co-Chairs, and I just want to say thank you to that.

Lt. Governor Jefferson Keel: Could I say something? She covered one of the recommendations that I had and one of them was going to be that in the TAC, when we talk about the Advisory Committee, and she touched on it; actually covered it very well that the TAC currently has no real role in the budget development process here other than looking and reviewing what's already been developed by the CDC staff. My recommendation would be that the TAC be involved, and through your leadership somehow, we get to the point where we can have a session where we look at the budget, particularly for FY16, we look at what the recommendations have been or are already on the table; because I know it's already been in discussions. We're gonna talk about that at HHS in a couple of weeks. And then particularly, moving forward, looking at FY17, looking at how we develop the recommendations for Indian Country. If, in fact, the TAC is chartered as an Advisory Committee to the Director then we ought to have at least a role in developing recommendations for the Director on how they look at priorities for Indian Country in terms of overall wellness. We heard yesterday about everything from safety to environmental health. We talk about mental health, suicide prevention, and all those things we need to develop some priorities for Indian Country on how CDC can address those needs. And I would recommend that we get together and determine how we can best resolve that. We've got technical experts throughout Indian Country that understand budget development. They get all the way down in the weeds with you on, you know, indirect cost, and all of those things. So our capacity has increased and it's at a level where we feel like we have some technical expertise to assist in that process. So it's time that we assume that responsibility also. And with that, we're almost at break time so we're gonna take—does anyone else have anything they want to add or did you want to respond? Did you want to respond before we go to break or... I see some anxiety here you know? I sense some strong feelings here.

CAPT Joe Maloney: So, hi this is Joe. So part of the discussion was what do we do with this photo opportunity for Dr. Arias? So Dr. Arias, we traditionally have a group photo with the TAC

members, and she's in the Ready Room so for the TAC members around the table we can just kind of regroup maybe by the door over there.

Lt. Governor Jefferson Keel: Ok, then let's come back in at 10:00 o'clock as best we can. Thank you.

Roundtable Discussion with CDC Senior Leadership

Councilman Chester Antone: Good morning again. We're about ready to begin our roundtable discussion with CDC senior leadership, and I would like to have the CDC senior leadership come up to the table. And I would also like to pass on this information to you for the CDC leadership to briefly introduce yourself and briefly mention your duties here at CDC because we're gonna try to direct most of the time to discussion; and so I'm gonna start off to the right side.

CAPT William R. Mac Kenzie: Good morning, my name's Bill Mac Kenzie. I'm the Deputy Director for Science for CSELS, which is the Center for Surveillance, Epidemiology and Laboratory Services. CSELS provides a broad array of cross-cutting services to support CDC partners. These services include the building and maintenance of information systems and platforms such as the Nationally Notifiable Disease Surveillance System that receives data from state and local partners and provides it to CDC programs. It is also engaged in Workforce and Career Development and administers training programs such as the EIS, the Epidemic Intelligence Service, the Public Health Informatics Fellowship, and the Prevention Effectiveness Fellowship. CSELS also provides laboratory standards and guidelines for the Nation and research and training in collaboration with FDA and CMS. Finally, CSELS is the home of dissemination of public health information for action through its publication of the MMWR, Vital Signs, and its work with the Community Guide Taskforce. Thank you.

Dr. Hazel Dean: Good morning. I'm Hazel Dean. I'm Deputy Director of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. Within our National Center there are five divisions. We have the Division of HIV/AIDS Prevention, the Division of Viral Hepatitis, the Division of STD Prevention, the Division of Tuberculosis Elimination, and the Division of Adolescence and School Health. Our mission is to save lives, protect people, and reduce health disparities associated with the diseases of our Center. We achieve this by the three goals of decreasing incidents of infection of these diseases, decreasing morbidity and mortality, and decreasing health disparities. We do this through what we call high impact prevention, which is maximizing impact through efficient implementation of cost effective and feasible interventions through our research and through our policies. Good morning to everyone.

CAPT Thomas Hennessy: Good morning. My name is Tom Hennessy and I'm here representing the National Center for Emerging and Zoonotic Infectious Diseases. We have seven divisions in our Center and are involved in a wide array of infectious disease threats, some of which include water-borne and food-borne infectious diseases, conditions related and that are controlled

through quarantine activities. Also, we have the Division of Healthcare Quality Promotion, which is involved in hospital or healthcare-associated infections. Three of our divisions are very actively engaged in Indian Country. The Division of Vector-Borne Diseases has the activities related to Rocky Mountain Spotted Fever that have been carried on for many years now with the Tohono O'odham Nation, St. Carlos Apache, and White Mountain Apache. Also, the Division of High Consequence Pathogens and Pathology is involved in a collaboration for many years with Indian Health Service to use the National Indian Health Service data warehouse to evaluate rates of infectious diseases among American Indians and Alaska Natives and that activity has produced over 45 reports that chronicle the improvements and challenges related to infectious diseases. I'm also the Program Director for the Arctic Investigations Program, which is CDC's field station for infectious diseases in Anchorage, Alaska, and we're located on the Alaska Native Medical Center campus and work very closely with tribal health organizations throughout the state of Alaska to augment their activities related to infectious disease prevention and control. We also operate and co-manage the Alaska Area Specimen Bank and I know there's gonna be a discussion later this afternoon on specimen banking. Some of you have visited that facility in the past, but basically, it's a collection of public health specimens and research specimens that are co-managed with tribal health authorities in Alaska. So thank you.

Dr. Corinne Graffunder: Good morning everyone. I'm Corinne Graffunder. I'm the Deputy Associate Director for Policy here at CDC so we're one of the OD offices that is a cross-cutting office. The mission of our Office is to identify in advance opportunities to use policy and leverage the health system transformation and other sectors to improve the public's health, and to do that we really have three priority areas that we focus on. The first is the identification of high value prevention in public health policies and interventions. So some of the kinds of work that we're doing there are work related to policy analysis, tools and resources to support policy analysis both within our Agency and to be shared with our constituents, economic analysis really looking at budgetary impact of some of the public health interventions and how you think about those impacts within a budgetary environment whether that's a health system or whether that's Medicaid, Medicare, etc. I should have started—I apologize—by saying our Director, John Auerbach, regrets not being able to be here with you all today. He actually is up in Maryland meeting with CMS colleagues today. So he sends his regrets and you got me instead. The second priority is to increase the understanding and use of credible evidence of preventions' impact by policymakers, healthcare and other sectors, and some of the ways again that we're doing this is we're working directly with CMS, we're working with the hospital systems, we're working with payers, providers, etc. to really try to work on that issue of how do you integrate population health and what we know from the evidence into this transforming health system. The last priority for us is really catalyzing collaboration within multiple sectors, multiple systems. So clearly a lot of our work is in the public health, healthcare system transformation space but we also have responsibility for the National Prevention Strategy and work with the National Prevention Council and through the health-in-all-policies kind of lens—we really are working to advance population health through housing, transportation, economic development, etc. So it's a pleasure to be here, thank you.

Dr. Katherine Lyon Daniel: Hi, I'm Katherine Lyon Daniel. I'm the Associate Director for Communication here at CDC. It's great to be back here and see some familiar faces again. Our Office serves the communication function in the Office of the Director. So each of the programs have their own very great communication offices and we work overall across CDC with the goals of helping our programs to communicate in such a way that is strategic, understandable, and actionable. And each of those three things take a lot of work, especially when you're trying to get scientists to communicate in a way that people can actually understand what they say. So we have in my Office the Division of Public Affairs, so all the media work comes through us and then to the programs. We work very closely with them and try to shine a light on the issues that are most affecting public health and communities. Then we also do communication services, so we're proud to work on videos and graphics and translations and all those kinds of things. Thank you again for coming. Pleasure to be here.

Dr. Harold Jaffe. Good morning. I'm Harold Jaffe. I'm the Associate Director for Science at CDC. Our Office is responsible for three basic functions that sound simple but aren't: science quality, science integrity, and technology transfer. And I think I'll leave it at that.

Sandra Bonzo: Good morning. My name is Sandy Bonzo and I'm the Deputy in the Office for Non-Communicable Diseases, Injury and Environmental Health, and our Office works with the four non-communicable disease centers, which include Dr. Bauer's center, Dr. Breyse's center, Ms. Dulin's center, and Ms. Patterson's center and they each will describe more in detail what they work on. Our Office is to promote, and to facilitate, and to coordinate the non-communicable disease work at the CDC. Thank you.

Dr. Ursula Bauer: Good morning. My name is Ursula Bauer and I'm the Director of the National Center for Chronic Disease Prevention and Health Promotion. Pleasure to be here again today. Our Center addresses the major chronic diseases, so heart disease, cancer, stroke, diabetes, arthritis, and so on. And the major risk factors, so commercial tobacco use, poor nutrition, physical inactivity and alcohol; although alcohol is disseminated across the agency in a number of centers that work together on that. We also have a strong Community Health program and we have in our Center an Oral Health portfolio and Reproductive Health as well. We work in four broad areas; epidemiology and surveillance, collecting data, using data, turning data into action, communicating data, getting data to decision makers for use; an area that we call policy and environmental approaches that's creating the communities that are going to support and reinforce healthful behaviors. The third area is working with healthcare systems to more effectively deliver quality clinical and other preventive services, so all of your cancer screenings, screening for tobacco use, management of hypertension and diabetes, and so on within the healthcare system. And then the last area we call community clinical links. That's helping people with or at high-risk for chronic conditions to better manage those conditions themselves; that's community delivery of self-management programs and supports and knowledge, that's connected to the clinic and that hopefully we're building a third party reimbursement for. Thank you.

Dr. Patrick Breyse:- Good morning, I'm happy to be here. My name is Pat Breyse and I'm the Director of the—recently hired director- of the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry, ATSDR. So I've been on the job for I think someone told me yesterday was my 7-week anniversary, so I'm really pretty new but I'm excited to be here, I'm excited about the work that we're doing and every day I learn more about what NCEH/ATSDR does and I just get more excited every night. So it's kind of a great job. We have within the two groups that I head, and they're separate but they're similar because they have similar missions and so I do wear two hats and I want to keep that clear. But we look to implement across these two Agencies and Centers the implement environment health programs and interventions that are evidence-based. So we're looking at things that we can do to improve health based on modifications we can make to the environment because the environment is our focus. We look to prepare and respond to public health emergencies, whether those emergencies are primarily environmental health related or whether environmental health is a component of that emergency response. So that's a big part of what we do, and then finally, our third major goal is to identify, characterize, and monitor health outcomes and environmental exposures. So there's a monitoring surveillance tracking component to what we do. And within that we've established four research topical area priorities and I think you'll see all these will resonate with what you're interested in. So the first one is asthma. There's an asthma epidemic today and we're really struggling with how to combat the asthma epidemic. There's a huge component of disparities associated with that. There's genetic component and it cuts across all aspects of society from the well-to-do, to the poor, and understanding those risk factors and what we can do is an important part of what we do. We have a focus on children's environmental health. It's a topical area that spans a number of Agencies across the federal government, and we have an important interest in children's environmental health, so asthma is a children's component but there's also an adult component to asthma, but we're very much interested in children's environmental health. We're interested in safe water and have a water program, and our niche there is we're looking at water systems that the EPA does not currently regulate so there's a large fraction of the U.S. population that uses well water, for example. And I guess that also applies to a number of your communities as well. And then finally we have I think the world's best laboratory for analyzing toxins and agents and chemicals in people's biological systems as well as developing new medical tests for looking at aspects of physiology that might be impacted by the environment. So we've been involved, as many of you know, with the tribal activities through a number of technical assists when those questions come in. We run the Navajo Birth Cohort Study through the ATSDR side of the equation. And I'm excited to learn more about what your needs are and I'm excited to help you understand what we're doing so we can be of better service to you. Thank you.

Stephanie Dulin: Good morning. I'm Stephanie Dulin. I'm the Deputy Director of the National Center on Birth Defects and Developmental Disabilities, and it's a pleasure to be with you here this morning. We have the honor of being the smallest but the mightiest Center here at CDC. We have a very diverse portfolio that we save babies, we help children, we protect people, and we help those vulnerable populations live with their disabilities to their fullest potential. And we do that through a variety of programs and categorical funding which you've heard about as we've

discussed over the last two days. But specifically what we do to help in saving babies is we do research to look at what are known risk factors that we can help mothers be aware of so that they can avoid those during their pregnancy; one of those being alcohol and alcohol-exposed pregnancies. And so we do a lot of work with our tribal partners in Fetal Alcohol Syndrome Disorders. Currently, we fund two resource centers, the University of Wisconsin and Denver Public Health and Hospital Authority to provide technical assistance on two interventions that we help to promote and that is the CHOICES- which is a behavioral intervention program- as well as Screening and Brief Intervention, which is a program or an intervention that is clinically set and done with both male and females to assess their alcohol exposure and to refer those folks to interventions throughout the pregnancies. So we're very pleased to be here. I have two of our SME's in the back that have been here for the last two days so if I can't answer any questions for you, I have my resources that will be here and will assist me. But we're very pleased to be here today with you. Thank you.

RADM Stephen Redd: My name is Steve Redd and I think I am the most junior person in my job on the panel. I have five weeks and two days in this particular job although I've worked at CDC for almost 30 years, so I have a little bit on the other side there as well. I'm Director of the Office of Public Health Preparedness and Response, and we have two primary missions. The first is to prepare the country for the next public health emergency and the second is to support the Agency's response in ongoing emergencies as we're doing with Ebola right now. We have four divisions. The Division of State and Local Readiness supports state and local and tribal entities to respond to public health emergencies. So there's a preparedness grant award that goes to the 62 identified grantees. The second program is the Strategic National Stockpile that purchases and stores material that might be needed for a public health emergency and also works to make sure that there are systems in place so that if those products are needed to be used that there's a system that can use them and dispense them. We also have two smaller programs, the Division of State...sorry... of Select Agents and Toxins that's a regulatory program that regulates and inspects facilities and laboratories that work on those pathogens or toxins. And we also have the Division of Emergency Operations, which is the home for CDC's emergency responses. It's a pleasure to be here and I look forward to the discussion.

Sara Patterson: Good morning. My name is Sara Patterson. I'm the Associate Director for Policy at the National Center for Injury Prevention and Control, and at the Injury Center, we work on two primary broad areas: unintentional injuries, which include things like prescription drug overdose, motor vehicle related injuries which I know you've talked about some and we'll probably talk about more today, older adult falls, child injury and many other topics. And the other main topic that we work on is violence prevention and that includes topics such as suicide prevention, child abuse and neglect, rape prevention or sexual violence prevention, domestic violence prevention, so the gamut of all of those areas fall within our purview and we do most of our work—we're a pretty small Center also. We're about 2 and a half percent of CDC's budget so a lot of our work is done by collecting data to understand what the problem is, trying to identify what works and really get that disseminated and we do that mostly through partnerships. We do provide some funding to states and localities and we have provided funding to tribes but a lot of

our work is done through partnerships and trying to work with organizations like the Indian Health Service, the Bureau of Indian Affairs, NHTSA, and many other organizations to get our mission done. So happy to discuss any of these topics with you and looking forward to it.

Elizabeth Dalsey: Good morning. My name is Elizabeth Dalsey. I'm here representing NIOSH. Our Director, Dr. John Howard, was not able to be here today but he says "Hello" and he looks forward to hearing our discussions today. NIOSH is the federal agency that is responsible for conducting research on worker safety and health. We want to ensure that workers come home as safe as when they left to go to work. We are...NIOSH is geographically disbursed throughout the U.S., and we have about 1200 employees. We do work in all different industries 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 worker injury, illnesses, and disease. And I look forward to the discussion. Thank you.

Councilman Chester Antone: For the TAC members, we'll now open it up for the discussion phase of this presentation. So if anybody has any questions they want to ask of any one of these representatives, I'll recognize you as you raise your hand. Geisler.

Secretary Adam Geisler: Good morning everybody. Again, I want to thank the CDC for organizing the TAC and the compliment that was given earlier was that this is an Agency that I think in relationship to other Agencies that I've come across that we work with on a government-to-government basis, you guys are off to a great start and I want to commend the leadership for the efforts that have been made thus far. But with that being said, there's obviously always gonna be room for growth and speed bumps along the way as we develop our relationship that we want to try to smooth out. Over the last couple of days we've had some pretty good discussion, I think, about varying issues as we've had different presentations from some of the directors that have come in to speak to us. With respect to the policy component, and I was writing down very quickly what each of the Centers do so I apologize if I can't read my chicken scratch. I really want to try to understand the policy integration with tribal components as you make your... as you review current policy. I think we discussed looking at, you know, we'd really like to understand because we realize there's limitations in terms of access to funds based upon legislation. There was a request this morning to try to get our hands on some kind of a list of funding opportunities that we are eligible for, and since you're going through and analyzing each piece of policy or legislation, I think that would be helpful. Another thing that we were looking at, and I apologize that this is probably gonna be very policy centric, but I've also found that that is the starting point for access and partnership. So the other aspect that I think I would like to understand more is how the CDC wants to or is looking to continue to include tribal specific language in its recommendations in policy development as it's coming down both from a budgetary standpoint but then also internally within each of the departments. And I apologize if it's agency department. Because we're seeing—and this is something I've learned over the last day, day and a half that I think that the will to work with tribes is here. It sounds like there are some aspects legally and policy-wise that we need to work through in order to achieve the outcome. Obviously, I don't think there's a tribe around this table that wouldn't like to see direct funding for different areas,

especially in terms of being able to collect the data ourselves, directly give you the data. I think in terms of the way that the structure is coming down from a policy standpoint everything comes from the feds to the state to the tribe and we're just kind of, if we're lucky, able to compete or go after or share information in that process, and I think that as much as that makes sense from a certain planning standpoint tribes don't always have the best relationships with their states because of other political issues above and beyond health components that aren't a priority to them. So I just wanted to put that out there for food for thought. The other comment that I had was regard to the public health and preparedness and response. I'm really curious how you're working with the Department of Homeland Security and FEMA specifically and their tribal liaison because we do have one tribal liaison for the Department of Homeland Security and one within FEMA. I do a lot of emergency management work as well and this has been a discussion locally within San Diego. Obviously, we're a large military town. There's concerns about we have a nuclear power plant down the road so there's all kinds of environmental components that are associated with this as well as the stockpiling components. So I'm just curious how you're working with Homeland Security and FEMA. Those are I guess two questions that I put out there to both of you.

RADM Stephen Redd: Actually, as you were talking, I didn't think I would get the first question, so I'm also going to give you a not-very-specific answer and I'll plead five weeks on the job. We recognize the importance of the collaboration with FEMA and DHS and we have actually had a liaison from CDC to DHS in Washington. That actually was a temporary position but I'm gonna have to look into a better answer to your question than I'm gonna be able to give right now. I think that the relationship between our office and FEMA and DHS is something that's really important because we do need a unified federal approach to emergency preparedness and really to bring in the public health part of that. So let me get back to you with a more specific answer.

Dr. Corinne Graffunder: You're looking at me because I'm from the Policy Office. Unfortunately, I think it's a broader discussion because the way our policy activity is structured at the Agency. We have policy activity in the Financial Management Office, we have policy activity in Judy's shop, there's policy activity across all the different Centers so they all have policy offices, so some of our responsibility is to work with and help support each of those Offices and to help strengthen the policy activities. So some of the kinds of policy I thought I heard you talking about in terms of some of the grant making and some of those things are probably better addressed either by some of the other folks around the room, because we don't have any programmatic activities in our Office. We don't do any programmatic grant making. So we could either see if others have some thoughts about that, or again, we'd have to follow up with you all. Is there somebody here from Sherri's office?

Dr. Ileana Arias: No but I'll have some of the policy folks who are here from the Centers can also speak to how it is that they approach it. One of the things that I heard you that we can easily do is be able to identify, for example, although we can't do it prior to actually publishing the FOA for the obvious reasons, what we can is be poised to once the FOA hits the ground to be able to then communicate with the TAC and then on further what the status of tribal entities is in terms of

responding for whatever is in that FOA. Is it possible, is it not possible. Sometimes it is, sometimes it isn't and there are all sorts of reasons why the difference may exist but at least we can convey that so that when the FOA is out, either I'm not even gonna fuss around with that one, or this is one that we actually can get funded by and so let's focus on this and tap into whatever technical assistance then there is back at CDC for addressing and being responsive to that FOA. So that I think we should definitely look into and find a mechanism for, number one, identifying the eligibility and then communicating that as early as possible.

Councilman Chester Antone: Thank you. I'll turn it over to Cathy Abramson.

Tribal Board Member Cathy Abramson: Thank you, Mr. Chair. I'll put this really close to me so I can save you a trip over here. I would just like to say, again, I appreciate all of you being here. I don't know if there's some of you that I know you have to be here because your boss said you have to be, but I appreciate it and I appreciate that you're listening to us. Again, I see better communications and that going on. I'm not going to leave anybody out in this question. I would like to- the question that I'd ask is, and go around the room, what is the one main priority identified in your Center addressing needs in Indian Country? And we can start over there.

Elizabeth Dalsey: We talked about this yesterday during our presentation but with our new American Indian/Alaska Native Initiative and our workshop is really trying to do an environmental scan, is trying to address and understand what are the priorities in Indian Country regarding worker safety and health and how we can address the needs and try to better understand how NIOSH can provide support.

Sara Patterson: For the Injury Center, I think our number one priority would be motor vehicle related injury prevention and we really have been very strongly committed to working with tribes directly and now through the TTAP program to try to provide technical assistance and resources to help with enforcement of existing laws and improving laws to make motor vehicle related injuries far lower in tribes because it's just such a huge burden. So that would be our number one priority.

RADM Stephen Redd: For the Office of Public Health Preparedness and Response, the highest priority would be that when a public health emergency occurs in a tribal area that the response is as effective as it could be and that the work has been done to be prepared to respond to that emergency.

Stephanie Dulin: For the National Center on Birth Defects and Developmental Disabilities, it's Fetal Alcohol Syndrome Disorders, and again, the work that we're doing is through the two technical assistance centers to help bring the two intervention strategies to Indian Country to help best intervene and reduce alcohol-exposed pregnancies.

Dr. Patrick Breyse: Do I have to give one?

Tribal Board Member Cathy Abramson: You can give two.

(Laughter)

Dr. Patrick Breyse: So, obviously, we're committed to the Navajo Birth Cohort Study but that's a very specific project so I'm not gonna mention that but I think a couple of things I would mention. One is clean water, access to clean water, and water distribution from droughts to excess to agriculture versus drinking. So there's huge issues around water. And then the other one I think is climate change and it's kind of related, so climate change and resilience in preparing for climate change I think are two areas that are important to us that would, I think, also resonate with you.

Dr. Ursula Bauer: Our priority, which we're in the process of implementing, is developing and delivering a more coordinated approach to chronic disease prevention and health promotion that brings together the resources and knowhow from across the Center and puts that out in a way that the tribes can own and make their own. If we have a chance to go around again, I'd like to come back to Adam's question because there's another issue we'd like to elevate to a priority around policy.

Sandra Bonzo: The Office of Non-Communicable Diseases does not have programs so we don't have one specific programs but we can work with the four non-communicable disease centers to determine how we can maximize our work across the four centers as it relates to tribal work.

Dr. Harold Jaffe: Our office also has no programmatic responsibility so I think we'll pass on that one.

Dr. Ileana Arias: My priorities are their priorities.

Dr. Katherine Lyon Daniel: From the aspect of Communication, I think my priorities are your priorities. So finding out what kind of information you and the people that you serve need so that we can meet those needs is paramount, and part of the difficulty there is that because we work on a federal level, often when we're getting audience research and information about what people want and need, it's such a small sliver of the data it's hard to get breakdowns underneath that. So I would love to have an increased way to get information from you about what you think we should be doing more of in Communication.

Dr. Corinne Graffunder: For our Office, we have had a priority through the work of the National Prevention Council that includes the Bureau of Indian Affairs of working with each of those colleagues around high priority prevention and health promoting policy systems in environmental change efforts. We're really focused right now on tobacco and on food working with colleagues in the Chronic Disease Center. I think the opportunity that I want to just mention is also with the work that we're doing in trying to really understand the health reform aspects including delivery reform and payment reform, figuring out who we could be collaborating with more closely to understand what that looks like in Indian Country would be an opportunity.

CAPT Thomas Hennessey: With regard to Emerging and Zoonotic Infectious Disease Centers, our approach has been to identify and characterize health disparities in Indian Country as a way of ordering priorities for applying subject matter expertise and consultation with tribal groups. Two of the examples that I mentioned earlier were with regard to Rocky Mountain Spotted Fever and then my own program, which addresses health disparities among Alaska Native persons.

Dr. Hazel Dean: In my Center, a priority is reducing health disparities across all of our Divisions. You heard from Dr. John Ward yesterday with the Division of Viral Hepatitis and their view on programs and processes that are in place for hepatitis. We have similar processes for HIV, STD, TB, our School Health program, as well. And for us we've already characterized the disparities and you've seen it in our publications. So now it's moving forward with programs and working together with you to make sure that we're actually reducing disparities.

CAPT William Mac Kenzie: Thank you for the question. For our Center we would focus on what the Community Guide Taskforce would put out, which works with all the other centers to provide interventions, information about interventions that would work within the Indian community.

Tribal Board Member Cathy Abramson: Thank you all. I just wondered with the HIV and AIDS. No tribes got any funding at all. So how are you going to address that so we could get some help that way because that's desperately needed?

Dr. Hazel Dean: So we're part of the policy dilemma of the first question, where our funding opportunity announcements are primarily the state and local health departments and we encourage state and local health departments to work with tribal communities. I see you shaking your head. So we're part of this policy dilemma that you're talking about where some of our programs are challenged in offering direct funding to tribes versus going through the state and local health departments.

Tribal Board Member Cathy Abramson: Thank you.

Dr. Ileana Arias: Just as a follow up, the Center has done an incredibly wonderful job at sort of tying the effort to data, and not only that, really monitoring closely just implementation but then outcome of that. And so one of the things as a follow up maybe that they can do is for those states that do have reach and should have reach to those tribal populations, maybe what is it-how is it that we're sort of doing it to make sure that that is happening both in terms of monitoring and then looking at the outcome and so we can follow up with that description.

Tribal Board Member Cathy Abramson: Thank you. That would be great.

Councilmember Chester Antone: Mr. Keel.

Lt. Governor Jefferson Keel: Thank you. Good morning. Thank all of you for being here and sharing with us. As a member of the advisory committee, and I've been a member since it was chartered, I've seen a lot of growth and a lot of progress in terms of how we're approaching the different subjects and different areas of need within Indian Country, but we still have a long way to go when we talk about the relationship you just mentioned between the states and the tribes. For some tribes in many states they have a good relationship. Most do not. Most of the states across the Country, for whatever reason, do not have a good, firm, smooth working relationship with the tribes. Tribes are not included in the discussions in terms of budget development and priorities, the surveillance activities are lacking and part of that is because of historic misunderstandings or problems within the different states. And there are a number of reasons for that. The fact is, tribes have been historically left out of the process of developing the priorities of need for their citizens across the Country. Again, some tribes have good relationships and we've been able to sit down with the state health departments and develop some of those protocols and communication and address many of the communication needs. But the fact is that Indian Country is severely lacking in terms of funding to address most of those needs. You mentioned Fetal Alcohol Syndrome, injury prevention, all of those things that affect Native Americans. Those are not just Native Americans, though, and we recognize that those problems exist across the community. But if we can improve the lives and the quality of life of our citizens within our communities, it raises the level and quality of life of all the people. So we're simply asking for—and we've made mention of this earlier, the TAC is going to be recommending to the director of CDC that the TAC be involved in the budget development process in the future. We want to sit down with the experts and we have technical experts at our level who are able to sit down and make reasonable recommendations on how these things can be improved, and we believe that going forward that will be an improvement in all of this. Not to say that we're satisfied with where it is right now because we're not. Indian Country cannot be satisfied until the needs of all of our citizens are met, and if you look at proportionately the number of Native Americans that exist within different states, there are some states in the Country that have no Native Americans to speak of. And so when we go to Congress to—we go to lobby Congress and I realize that your relationship with Congress can't do that but we can and we do. But the problems that we run into is that most of the states, 430 people in the House of Representatives, only about 350 have—or 350 don't have any Native Americans. Only about 75 of those congressmen have Native Americans within their districts. So it's an education process for us continually. It doesn't mean that we don't reach out to all of those others because we do, but it's very difficult for us to go when we don't have the right materials or information, and when we talk about surveillance, the data collection, it would be beneficial to us to have those highly trained and highly skilled CDC folks in each region of our areas, particularly those that have high concentration of Native Americans so that we can, as Dr. Giroux yesterday pointed out to us that we need someone who speaks the CDC language. Realizing that we all speak English but there's a lot of lingo that's spread around that we sometimes don't understand. You know, acronyms and those kinds of things. So if we can have those folks in the regions in our areas who understand and who can help us to get there, I think it will be beneficial for all. So that's gonna be one of the recommendations that I make is that going forward the TAC be involved in the budget development process, and I'm saying that to all of you so that you know that, yeah, it came from

that guy; you know, he's the guy that started this. And I think it will be helpful not only to Native Americans, I think it will be helpful to you in your position to understand why we're asking for these things and develop this positive relationship. Historically, the federal government and the tribal governments have had this adversarial relationship for a number of reasons. Well, we're at a point in our history now where we can move forward. We don't have to agree on everything but can we live—we can get to a point where we can continue to move forward. So thank you.

Councilman Chester Antone: Joe.

Joe Finkbonner: Thank you, Chester. I want to thank you all for being here. I know that it may seem like we don't have a whole lot of questions but it's actually the opposite way around. We could probably spend an afternoon with each one of you individually and occupy the whole time. If you just take a look at the disparities in Indian Country and the portfolio that you work with, you'll know that we have a lot in common to talk about and I appreciate that you're all here and are making the efforts to reach out. And I want to have...I like the format that Cathy brought up of asking you each individually to respond to a question, and I want to exclude OSTLTS from the answer of this question for my own edification here and that is, if you had a specific effort within your program or your division that you wanted to work with Indian Country, who would you call first? That just helps me with some insight of who we need to work with in order to be able to—public health is about personal relationships and I guess I just want to know where you are getting your advice from, who you go to to get advice on how to work with Indian Country.

CAPT William Mac Kenzie: So as I stated before, I would probably go to the Community Guide Taskforce to discuss potential options for getting more information directly with regard to Indian Country and interventions that would work effectively; therefore, motor vehicle injuries, alcohol, etc.

Dr. Hazel Dean: So my response is two-prong. First, I would go to Judy's office, OSTLTS, and talk with her tribal liaison to get permission to talk to Chester. I've known Chester for a long time.

CAPT Thomas Hennessy: Well, wearing the hat from the Arctic Investigations Program, I would probably reach out to Roald Helgesen at the Alaska Native Tribal Health Consortium who we work closely with. The other person I would speak with is—within the State of Alaska Section of Epidemiology there's a designated tribal liaison, her name is Louisa Castrodale, and that's been part of an effort from the Consulate of State and Territorial Epidemiologists to identify within each state a person who can be a designated person to work on American Indian Alaska Native issues. So those are the two people I work most closely with.

Dr. Corinne Graffunder: We would also go to OSTLTS just because depending on the nature of the question that we had. We would look to them for advice about who to talk to as a starting point.

Dr. Katherine Lyon Daniel: I think it's difficult for those of us on the OD because we are trained and directed to go through the proper channels. But I think if you were asking me from a communication perspective where would I get the information, we would probably go to some of the smaller surveyors or audience analysis groups that do research and try to get some information from them that are databased as opposed to going to an individual.

Dr. Ileana Arias: The only entity is STLTS. Other than that, it would depend on the issue and really it's sort of depending on what program who have they worked with, what has been profitable and what hasn't, and then moving forward on the profitable side and if we need to use the ones that haven't worked as well, why didn't that work and what can we do. So a lot depends on what relationships have already been created.

Dr. Harold Jaffe: Again, we don't have any specific programs, but if a question arose, I think we'd start with Judy.

Sandra Bonzo: Again, for us it would be OSTLTS but if it involved one of our centers, we would go directly to our centers and make contact with the subject matter expert in that area.

Dr. Ursula Bauer: I take a three-pronged approach. I begin with the TAC when I have questions. I bring those questions to the TAC and we've had a lot of good discussions here over the last four years. The second thing I do is I visit. I can't visit everywhere but I visit a number of places each year and I learn what's going on on the ground and I talk to people who are Native Americans, Alaska Natives working in Indian Country. I talk to tribal health leaders. And then my third approach is more informal. I identify people that have brought problems to me or brought solutions to me, even better, and ask them to convene a group. And, again, I've gone out – I did this in Northwest Portland area, go out and visit and tribal leaders will come in and meet and we'll have a discussion. So those are my three strategies.

Dr. Patrick Breyse: So the Pat answer is probably not what you're looking for but I'll tell you first I'd start with calling Annabelle because she used to work in our group and she's still an important part of our group. We include her in a lot of our leadership meetings and stuff, so I want to make sure I keep that bridge open. And I also talk to Annabelle when I—similar to what Ursula just said—I'm about to go visit regional offices so we have regional staff across the country and as each of those regional office visits if there's a tribal entity close by or that's appropriate, I'm gonna try and meet with them to develop those personal relationships because I agree it's also personal. I've done work in my previous life with tribal populations in New Mexico and the State of Washington and other research settings. We did some indoor air quality studies in Navajo. So I've worked with tribal entities before and I look forward to developing the personal relationships that you talked about so I can hear the kind of things that were mentioned in terms of what are the needs of the tribal entities, how we can better fill those needs and how do we make sure people are aware of the funding opportunities that are coming through our center and how do we make sure you're well situated to take advantage of those funding opportunities as well.

Stephanie Dulin: For us, we would go through OSTLTS. We currently have quite a few projects that we're working on with OSTLTS to reach tribal communities; one being spoke earlier about methamphetamine use. So our go-to is OSTLTS.

RADM Stephen Redd: I would also begin with OSTLTS but I would actually ask for advice. That would only be kind of a pass-thru of who is it that I need to talk to, and use that as a way to find the right person to talk with.

Sara Patterson: We would probably use our informal channels in thinking about the different topics. So kind of like Ileana was talking about. There are so many topics that we've already been working on that are a priority for us, so I'd go to the people that we've been working with and try to figure out if that's the right group or if we need to expand our network more. But if it's a topic that we haven't worked on and we need to explore more, we'd go through OSTLTS and engage this group.

Elizabeth Dalsey: As mentioned by this group, we also would start with OSTLTS. This is still a new initiative for us and they've been very helpful as we've started. We have some informal contacts, Navajo OSHA has been extremely helpful and so has Ramona. So we would start with those relationships and hope to build more.

Councilman Chester Antone: Thank you for your responses. I kind of want to save mine for the end but I could do it now. Mr. Flying Hawk.

Chairman Robert Flying Hawk: Good morning leadership. I'm the representative from the Great Plains Area and as you're probably aware of, we have a question with a pipeline, and I did hear a response earlier about some water, and we are looking for the well-being and the overall health of our area. So I just wanted to throw out a question regarding that if there was any kind of a response in the ideal world, it would all be good but if something did happen, what kind of a response would we be available to or would we have?

Dr. Patrick Breyse: I'm not quite sure what you mean by response. If you can elaborate for me a little bit, then I'll tell you what I think.

Chairman Robert Flying Hawk: I guess I'm saying in the ideal world everything would work, the pipeline would be intact and there would be no spills, no breaks. If a break did happen, the water table, and the effects on that water and anything else, our crops, the land itself.

Dr. Patrick Breyse: So that's a fantastic question and it's a very difficult question to answer. Obviously, there's a lot of political aspects to the pipeline you're talking about but we did, for example, respond to a broken pipeline a couple of weeks ago carrying Bakken crude into the Yellowstone River and we respond to events like that way too frequently in my opinion. But I think we're learning from our experiences about the pipeline breaks. We know a lot about how to respond to them. Obviously, the solution is to make them so they don't happen, but it was

impressive to me that in this case when the leak occurred, it was detected by a fail-safe system in the pipeline. The pressure dropped right away so we knew about it. It didn't occur for long periods of time until they were able to address the problem. There was a water system that was affected. We worked with the local groups to minimize the effect to that water system and so we're postured, we're ready to respond to those things when they occur. And I think we'd also like to participate in a bigger discussion about how do you make sure that they don't occur rather than making sure we're ready to respond to them after they occur. And I think that's a different question and that's probably a bigger discussion that what occur in a Center such as mine.

Lt. Governor Jefferson Keel: I have a follow up to that, and you mentioned about, and I agree, that the best solution is to make sure it doesn't happen. But across this Country, we've got pipelines all over the country, you know. We've got this tremendous—if you want to talk about structure and infrastructure, we've got pipelines all over the Country in every state going towards the South and I'm not sure how often those leaks or breaks occur but I know that they do, and I know that the response is often delayed for whatever reason, maybe political, maybe financial, whatever. But disregarding all the political aspects of this, forget that whether we like it or don't like it or agree or disagree. If it happens, when we talk about the aquifers and the damage that's going to occur or may occur to the water supply but it's not just the water supply water that's damaged. It's all the other things that depend on water. So I guess my question would be are tribes being consulted in any of these types of discussions surrounding the prevention activities and solutions or whatever?

Dr. Patrick Breyse: Just to be clear, so we get involved when there's a spill and we get invited to be involved. So we know about ones that happen and we get invited to assist. So you're right, there's probably others that occur that are not on our radar and I don't think there's a—I'm not aware of a national database that tracks these things in terms of how frequently they occur. Of course, the environmental health problem is much bigger if it's a ground water problem in addition to or instead of a surface water problem. I'm not sure...It would be a much bigger response if that were the case. But the national-level discussion you're talking about I think goes beyond certainly what my Center might participate in and I think maybe a broader CDC focus could participate in that. But I think it needs to occur and I'm not sure how you get to where you want to be but if we have any advice to offer, I'd be happy to kind of participate in that.

Dr. Ileana Arias: I can't offer you any specifics, but I know that there are inter-agency sort of meetings where we attend but we have a very small piece of that, as you can imagine, since a lot of what we're talking about, especially in the prevention side, is a regulatory issue. Department of Defense...I'm sorry Department of Interior usually is the one who is the primary one for—they will reach out to us sometimes to sort of address health issues that they may feel they need to address as they do their work, but both in terms of the inspection and then how is it that new construction efforts get approved and what are the requirements for them in order to prevent those health issues, a lot of times it's an Interior issue.

Lt. Governor Jefferson Keel: Thank you. It occurred to me probably EPA and Interior and all of those would be—okay, thank you.

Secretary Adam Geisler: Dr. Bauer made a comment about circling back so I don't know if this would be an appropriate time to circle back but there was something you wanted to reflect on?

Dr. Ursula Bauer: I wanted to respond to your policy question and tie it in to the priorities question. So thinking about policy with a capital "P". I was thinking back to the American Indian Healthcare Improvement Act of 2010 and the public health authorities that were given to the Tribal Epidemiology Centers and I would like to see as a priority for the Agency and certainly my Center as well how we work with the Tribal Epidemiology Centers to develop the capacity to take on and wield that authority.

Councilman Chester Antone: Ramona.

Ramona Antone-Nez: Good morning. I'm Ramona Antone-Nez and I represent the Navajo Area...Navajo Nation. I'd like to say thank you for inviting us to your facility here at CDC. It's wonderful to be here and get to meet you. What I'd like to tag on to what Dr. Bauer had talked about in terms of the Tribal Epidemiology Centers as public health authorities. I've stated this earlier just shortly after Dr. Monroe had provided an update, and many of you were here or weren't here; I didn't recognize whether you were or not, but I just want to emphasize that there is a request that Career Epidemiology Field Officers are identified and deployed and assigned to the various Indian communities and to help us with this part about the public health authority and the need to identify and establish surveillance systems in Indian Country. I also want to go back to the priorities based upon the CDC FY 2016 congressional justification proposed budget. Identified in there is the HIV and AIDS, that there is a budget increase of approximately \$12 million. There is a need specifically for Navajo area for increased prevention and in the linkage from secondary to tertiary care when we get to treatment. So I'd like to just put that there for CDC in terms of these proposed budgets that were identified, I see that there's an increase overall that you keep Indian Country in mind. I know there's increased dollars proposed but to be more resourceful about how you allocate those dollars and identify where—each of you have identified the priority areas about where you can improve services to Indian Country; I just would like you to keep that in your forefront although we are part of a population that is a smaller percentage nationwide; however, I want to emphasize that government-to-government relationship that we have and to be identified as such. I also want to bring in one more part about those states that are being direct funded are funded through any one of your grants. My question is how accountable are they to the tribes when they identify many of the health disparities that are—they use to get an FOIA. And then once they are awarded, who goes back and says how have you actually met these justifications or these objectives when you identified perhaps tribes as where you would provide your scope of work? Because we have experienced such practices from the states now; I want to also state that there are different states who work very well with the tribes and then there are others that that relationship can certainly be strengthened. So I'm just asking that when they report back to you via their annual reports, semiannual reports, to keep in mind

how well are they implementing their scope of work in what they said they would do in servicing the special population areas and specifically to tribes. So I just want to put that....Mr. Chair.

Councilman Chester Antone: Thank you. Are there any responses to Ramona's questions?

Dr. Ursula Bauer: So Ramona, based on guidance that we receive from the TAC, we do not fund tribes through state health departments. We fund tribes directly or we fund tribal organizations. We certainly allow state health departments to work with tribes if they're going to do that, they state that in their application and they have a letter from the tribe describing the partnership.

Sara Patterson: I can just add from the Injury Center, one thing we really try to do when we do support states or localities that are engaging with tribes and their work, we really try to highlight that so when we're writing our CJ, when we're talking about the work that's being done at the state or local level, we really try to highlight those partnerships and where that work is being done well. I think that helps us to kind of make the case for the need to link that state and tribal relationship more and try to identify interventions or tools or resources that can be really part of a collaboration between the tribes and the states. So that's one thing, although we don't fund a lot of tribal work directly, we really try to augment the stories that we tell about that, and this gets back to the comment earlier about talking about the budget. We really think it's important when we're talking about the way our resources are used to explain how they get used in a way that's really impactful and that's something we can work on is messaging together about how the resources that do get used at the state or local level are effecting your population and that really can support your constituency.

Councilman Chester Antone: Oops....Delia.

Tribal Council Member Delia Carlyle: My name is Delia Carlyle. I'm from the Ak-Chin Indian Community and a Phoenix Area delegate. I really appreciate all that you've said today. I was telling others earlier I'm like a big sponge. I'm soaking up so much information and my tribe actually has received some small grants for emergency preparedness and all, water issues with that. My question...not my question...I guess basically my comment, I hear a lot of talk about obtaining data and I hope that all the data relating to Native Americans is collected and not lost somewhere. My daughter had...was diagnosed with triple negative breast cancer. We were like, what the heck is that? It turns out it's a rare, it's probably it's one of the more aggressive, can only be treated by chemo and radiation. You know, typical medicines won't work for her. And what I'm saying is that she was diagnosed through the IHS system but then she was sent out to you know Chester will understand when I say "milgan" - the non-Native world- to be taken care of. And so I would like to think that any kind of data you receive—and I know that's just a personal story—but we had so much—we met hurdles in trying to get not necessarily services but information on what this all entails. But we were able to do that, and when you talk about data, I'm just hoping that those that hit those minute smaller percentages, they still count, and they still mean something that could help someone. Even like with epileptics. That is another area that we see is happening, and unfortunately I lost my granddaughter to epilepsy. She had an epileptic

seizure. She was seen, but for whatever reason it just never—she was through so many doctors that we just don't know what really happened but it was a seizure that took her life. But again, any number, no matter how small, should not be forgotten. So I keep hearing about the data collection so that's just what—I'm just putting that out not just for what's happened to my family but others that we know that it's happening to out there because I hear all – you know, what we're talking about and it's good but let's not also forget those that may not be in that high priority but they are...they have experienced something that hopefully the information can be used to help others, or even prevent, if that's possible. That's just my comment. Thank you, Chairman.

Councilman Chester Antone: Thank you, Delia.

Dr. Katherine Lyon Daniel: If I could just respond. First of all, please accept my condolences on the loss of your granddaughter and I hope your daughter does well. I think that you all know very well the power of the story, so when it comes to communication, yes, we want to make sure we give everyone information that's based on that data, but the personal narrative and how people are affected by health issues is often what drives either the funding or the listening or the focus on an issue. So I encourage you to not only keep telling your stories and not think of them as just an anecdote but also to share those stories with us. We have a story bank of how we work and if there is a way in which you or any of the people that you know have worked with CDC and you can tell a story about how it affected someone's lives or how it could have but didn't, those are very powerful and we would love to have those shared through Judy's office or any other way that you like.

Lt. Governor Jefferson Keel: Your turn.

Councilman Chester Antone: Okay, my turn. I'll just throw out some questions in between this discussion that I'm gonna have with you and if you can pick it up, you can respond. If you can't respond, just take it for what it's worth and give some thought to it. Last month, at the STAC meeting I had a discussion with one of the federal folks there and I told her, I said, you know, this access to care, this whole Affordable Care Act thing speaks to a change in the history of Native Americans as far as policy...health policy, government-to-government policy. And I told her it is one of inclusion if we choose to look at it that way. But along with that we need to discuss and maintain the trust responsibility. And I was telling her, I said, maybe in about 30 years you'll probably be the one to write about that. That shift that has been occurring over the last 3 years, 4 years, more so the last 3 years and if we're included and we have access to care under the Affordable Care Act, then we ought to have access to the budget, too. Because the best example that I have, and I don't know if there was any support given for the Arizona's Uncompensated Care from here which I had requested the previous year that we needed support to pass that, or to renew that uncompensated care cost. And the reason why we did that was because the state legislature of Arizona took out a lot of those optional benefits that were beneficial to us and we worked out a scheme to where the CMS through the State of Arizona would reimburse Indian Health Services to provide certain services that the state did not have in their optional benefits

package and would not allow it. This past year it was renewed again because the state does not have that option for American Indians. Some of the options including emergency, dental, podiatry. I think the only thing they had in there was insulin pumps. So it is possible to direct fund tribes but I think we need to think outside the box in one way, because if that can happen directly from CMS to the State of Arizona to the Indian Health Service reimbursement, which in turn provides more services from the IHS, then it's possible here at CDC. And Mr. Keel was talking about that. If we have some access to putting our items on the table, overall Indian Health Care and perhaps specific to some areas that have very high rates of x-number of things, then it is possible because it can use that example. Going around certain things. That's why I said yesterday I know we can do it some other way. So I wanted to give you that much as far as an example. The other thing is CMS, we are going to approach CMS further on down the road to talk about reimbursements for traditional healing practices because I know that that's a major collision there when it comes to federal regulations versus what the Natives know helps them out, that's beneficial to them. So I wanted to give you that scenario and I also in this writing thirty years from now when people write about the inclusion of Native Americans into healthcare and really at different levels of the government more so than ever before in this Administration, people look at it as assimilation of the Native American into the overall Western philosophy. But the difference between there is it's not so much assimilation as it is acculturation that we have come to certain points in our tribal lives that there are some things that we want to do. So it's not coming down at us, we're going up towards it because we realize the benefits of it. So that concludes that part. There's more to come.

I want to thank those folks that brought to us—or to my question a few years ago regarding the Fetal Alcohol Spectrum Disorder. That web page was provided but I think we need to focus a little bit more on that particularly when it comes to Natives because I don't think even though it was provided through my legislative consult in my report, that I don't know if anybody really understood how to approach that. So maybe a little primer on how to do that. And this is the team diagnosis of FASD. We realize that many physicians are reluctant to diagnose that on their own but this is really a team effort that I think is really gonna be helpful.

I want to thank the CDC for their response to the Rocky Mountain Spotted Fever, particularly in Arizona. We have had people from here detailed out there and we really appreciate that. It's still there. It's one of those diseases that when there is no additional incidences, or so we think it's still there, it's an invisible kind of thing. It's very visible at first and then it kind of dies down. We always have to be vigilant on that and we still have to get on top of IHS to keep maintaining that protocol that they have because they have a tendency to slip sometimes. So we have to do that every so often. We also made a recommendation for the Strategic National Stockpile that when you dole out the medication should it become necessary that the IHS will be the best place to do that. Otherwise in our Nation we have three counties which is Maricopa, Pinal and Pima and so if we go to the counties—we will do like the last time...which was really good last time because we got additional vaccinations. The IHS provided this and then some of the counties also provided that because we didn't have that straight line of distribution, so we got additional which is good. But I think if we didn't make that recommendation at one time, somebody asked by email or was

it discussed here or on the phone but we did recommend that since IHS is in each area where we have tribes, that probably would be the best way to funnel it because they know their area. On the foodborne, I don't know the infections. Currently, we are developing a food code over at Tohono O'odham Nation. We have a food policy that's gonna back it up, so one of the things there is that we... one of the problems that we run into is we have feasts and food is cooked so the thing is, when you regulate it from the tribe, it's not too popular. So one of the things that we're looking at is how to be able to achieve that. We know Gila River has – they have a really good program. We've visited them and so that's just to throw it out that they might be coming from Indian Country somewhere down the road. And I just want to reiterate what Mr. Keel said regarding the budget and the inclusion of us because we're included at other places. But I think the system here or the process here is so rigid that people won't go beyond that. I took that seating arrangement and showed it and I said this is an example of the rigidity that exists here because it kind of shows us that this is the place where this exists. And I can understand why but we can address that again later. My last comment is a long time ago, I met Hazel and we were discussing the social determinants of health. I still maintain that if the tribe knows and is able to measure their progress with regards to the social determinants of health, I think we can better plan the next steps. But we need to know how we're fairing with regard to other Nations. It's very important and it kind of goes everywhere and I'll leave this discussion with this example. I was living in Tucson and my sister kind of has like a disability. She has a low white blood count, or so they say she's very susceptible to infections. Actually I used to call the ambulance quite often to the apartment because not realizing that the carpet, you can see it when the sun comes in, you can see those little things flying around. That was doing most of that. I've had to call I don't know how many times and the fire truck will come over, the ambulances will come pick her up and take her to the hospital and she developed an infection. Then the home health nurse has to come by, so she's okay for a while and then it happens again. But my district, the Pisinemo district, saw the need that she had and were able to come up with some funds and they built her a house; it's tile

This in March will be the second year that we've been there. Not once have I had to call the ambulance. Now, to me it has something to do with the social determinants of health where our standards have risen to a point where there is not—if you'll take out the possibility of infections whether it be to a structure, whether it be through intervention or whatever policy we have, then you can see the difference. I've seen it. But to me, it comes in the form of housing, good housing, because our old house had all kinds of holes in there so every time we went to visit the Res she'd come up with an infection. Now she hasn't and I really don't know how to frame that as far as the social determinants of health but it gives me an idea of some of the things that Indian Country needs to keep their workforce healthy to be able to provide for the Nation. So I wanted to just say that much as far as having you all here to share that with you, all of the things that I did because I've been here for quite a while with Jefferson and I've heard many of these things that have never been addressed. But I think we're in a new direction now because we're starting that conversation again. Testament to that is Ms. Bauer's Center over there. Now if we can get other Centers to look at that that way, we would really be off to a good start. Is there anybody else want to make some comments? Actually, we're at 11:30, a minute over. Quisno?

Council Member Patricia Quisno: Yes, I'm Patricia Quisno from Montana, the Billings Area, and specifically from Ft. Belknap. Ft. Belknap is located approximately two miles from the Burlington Northern or Santa Fe Railroad on which runs 100 count at least oil carriers which because this pipeline...I was reminded of this by Mr. Flying Hawk. These 100 mile oil carriers go through I'm not sure how often but I see them very much of the time and I'm wondering if CDC has had any heads up or any contact with what might happen if these went off the track, especially going through the states of Idaho and Washington where they would contaminate rivers and I don't know what. To me it just seems like an accident waiting to happen and I'm just wondering if CDC has any plan or if you've thought of anything in case something like this did happen.

Dr. Patrick Breyse: So we have thought of that and we are planning for how that response might be. You're absolutely right, there's a lot of oil product now being shipped on rail; more and more every day and it's tied to the pipeline issue. The argument is we can't put it in the pipeline, we've got to put it on railcars. And they're going through the same sensitive areas that the pipelines are, so it's one of those things you hope to God never happens but we're thinking about what that would look like if it did. And hopefully we'll be ready to do the best we can at that point.

Lt. Governor Jefferson Keel: I would also say that it's not just oil that's being transported. A lot of other hazardous waste type things. So it's an EPA problem also.

Council Member Patricia Quisno: It's just so much oil. It's just so obvious, you know.

Councilman Chester Antone: At this time we'll go ahead and end this discussion. I want to thank all the federal partners and everyone for their questions and their responses. It's really helpful to be with the leadership here just as we do at STAC, we do the same thing. And so right now I'm gonna ask Ms. Fetherolf, Romana to give us a little update from this morning's session and then we'll go to lunch.

(Inaudible.)

Romanadvoratrelunder Fetherolf: Good morning. My name is Romana Fetherolf and I will be providing the morning session summaries. Dr. Arias gave an update from the Office of the Director. Dr. Monroe gave an update from the Office for State, Tribal, Local and Territorial Support. As follow up, we will send TAC members the link to the Public Health Law's, Tribal Law web page. Dr. Monroe discussed the Public Health Associate Program and mentioned that we are dedicated to increasing placement within tribal entities and organizations. As follow up, we will send TAC members information on PHAP, the Public Health Associate Program. Ramona Antone-Nez made a recommendation that Tribal Epi Centers be able to make recommendations on placement of field epidemiologists. TAC members also made the recommendation that the TAC become more involved in budget and funding for tribal entities. During the roundtable session, CDC senior leadership gave descriptions of their Centers and Offices. And TAC members

and senior leadership engaged in discussion on topics including but not limited to priorities, policy, and budget. Have I missed anything?

Councilman Chester Antone: Before I excuse us all to go to lunch, I was telling Dr. Monroe regarding the PHAP, Dr. Freiden sent out an email to all tribes regarding the PHAP and I wanted to be sure to mention that because I know I got one.

Dr. Judith Monroe: And one last thing. There's a request for a photo op with all the senior leaders. Adam is our new member of TAC and has a camera...got a phone... so where did you want to do that?

Secretary Adam Geisler: I thought maybe the staircase or in here? This is...the reason I'm asking for this is, again, because this is unique in the way that senior leadership is sitting at the table and having this dialog today, and so it's twofold. Obviously, I'd like the opportunity—what I'm gonna be proposing this afternoon is actually that in order for us to effectively have conversation with Congress, it would be great to walk in with facts. You collect all the facts. So it would be great to get a report from you, from each of you, compiled into something that shows the status of CDC issues in Indian Country. So you might not be able to say it but we can. What I'm hoping is that this picture would go on the cover of that report. (Laughter) The other reason is that I want to be able to show other federal agencies how well you are working with Indian Country and the efforts that you're making because I'm not joking when I say it's unique. It's very unique to see this level of engagement and I'm happy to see it.

Native Specimens

Councilman Chester Antone: (Inaudible.) Presentation...If I could have everyone return to their seats. And for this presentation, we have Michael Shaw, Office of Infectious Diseases, CDC and Chair of the CDC Specimen Policy Board. We have Stacy Howard, Associate Director for Policy, Division of Laboratory Programs; and Delight Satter, Senior Advisor for Tribal Research and Program Integration. And we're ready to go.

Dr. Michael Shaw: Thank you Mr. Chairman and other council members. We really appreciate this opportunity to present some of the issues we are all dealing with, and what we would like to do is give you an idea of the policies we have in place, how human specimens are handled, how they are used, and also the path forward for establishing a new policy should that be decided to be needed. First, I want to go into the policies and practices because it's important for you to understand what's in place now. The policy we have is one that is actually fairly new, which I'll go into some details but it has evolved over the years into its present form and it's a fairly comprehensive policy. It's not specific to American Indian/Alaska Native specimens. It covers all collections that are in CDC possession. To give you some background, CDC Laboratories are spread all over the Country. There are at least 1,000 rooms of laboratory space, probably 150 different laboratory units. Each of them maintain their own collections of different sorts of

specimens, and they collect a wide variety of types of specimens. This makes it especially challenging to get a policy in place that can adequately tell people how they're supposed to handle the specimens that they do have. We estimate right now that we have inventory and documentation for over eight million samples. That includes clinical isolates, serum, urine, other patient samples, also the bacteria, viruses, and other pathogens that have been grown from these samples. This eight million includes everything that we've got. It's domestic, it's international and it represents probably the Nation's preeminent reference collection for pathogens. A governing policy had to be established to try to harmonize all of these different specimen management practices because obviously a laboratory dealing with viruses would handle specimens differently from a laboratory handling environmental specimens. So we tried to establish a standardized approach so that everyone was using the same basic criteria for managing their specimens. What arose from that is the CDC Specimen and Sample Management Policy. This is an official CDC policy that came into effect in December of 2013. It's MASO-approved and all of CDC agencies are working under this policy. The purpose was to have, as I said, some sort of uniform requirement for managing, tracking, and safeguarding the specimens that we receive in addition to the specimens that are generated internally. As I mentioned, we often grow pathogens from the specimens that we get in. We often make derivatives, which I'll get into a little later. All of these have to be accounted for. The Policy Board was set up under this policy as the senior leadership body to advise the CDC Director. It has representatives from all of the major activities at CDC. It meets regularly to discuss specimen management issues and to delineate the responsibilities of the different groups throughout the Agency. It's applicable to all domestic CDC laboratories and all of the staff working there who either receive, store, or manage specimens, or are involved with maintaining the specimen inventory and any staff who oversee or participate in any of these activities. So it's all encompassing. The Policy Board itself, as I mentioned, is specifically set up to advise the CDC Director on specimen policy issues. The duties include that we monitor progress of the different groups with implementing the policy. As you might expect, some groups are farther along than others. The duty of the Policy Board is to make sure that no one falls behind, that everyone is aware of the policies and is implementing them. They advise the programs on particular policy issues they may have because of their particular circumstances, and also responsible for communicating any revisions to that policy that arise from special circumstances such as outbreak investigations, emergency situations where things may have to be changed depending on a very fluid situation on the ground. They also recommend appropriate actions when a group is not adhering to the policy. Noncompliance is taken very seriously. Everyone is expected to treat these specimens with the proper respect and also to maintain scientific integrity. To be quite frank, specimens are not going to be of great deal of use unless you have the data to back them up; where they came from, what sort of situation warranted their collection, as much information as possible. So if that isn't included in the inventory, then it becomes less useful. As I'll describe a little later, in different situations, different degrees of information are available. But one of the things we're trying to standardize is the type of information that is going to be held at a minimum for every specimen coming in to the CDC or created at CDC. The final responsibility of the Policy Board is to create an annual report for the senior leadership which gives basically an update on CDC specimen holdings and any issues that have come up within the past year regarding those holdings.

Specimen identification is obviously something that's of great deal of concern to this group in particular. I think you're all aware of the issues that happened over the summer with laboratory safety in general, but one particular issue that affected all Agencies in the U.S. government was the discovery of smallpox in a place where it wasn't expected. That led to the secretary requesting that all Agencies in HHS, and later this was expanded to all U.S. government Agencies, do essentially what they were calling a clean sweep; go into all of your facilities, look to see if there was anything out of place. What we did at CDC was we decided to take advantage of this process and implement a full inventory of what we have. That vial-by-vial inventory is underway as we speak. Some groups have already completed it, others have asked for delays because of outbreak response. Obviously, the Ebola group doesn't have a lot of time to go through their freezers and look at every vial. The measles group similarly is very busy right now. So we make special allowances for situations but everyone is expected to complete this inventory. In the process of doing this inventory they're asked to pay special attention to any collections that may contain American Indian or Alaska Native specimens and they're to let us know about those. If they're uncertain about them, then the groups are being asked to trace all the documentation that they have available for these to see if it's possible to identify the origin. Now, in some cases, CDC has legacy collections that go back decades and decades, some of which have been inherited from retiring academicians. We have no control over the metadata associated with those specimens but whenever possible we're trying to figure out the origin of them because as I said, the more data we have about them, the more useful they are scientifically. We're also asking the groups to identify derivatives of any American Indian/Alaska Native specimens, and by derivatives, I mean anything that was created from the specimen after it got here. For example, we might get a stool specimen as part of a surveillance project from which we were trying to get an idea of the prevalence of polio in the population from some very old study. Derivatives would be any viruses that had been grown out of those specimens, any DNA or other nucleic acid that had been isolated from them. If they're histology specimens, say a biopsy or an autopsy specimen, there might be slides with the fixed cells on them that are also being kept. In some cases for tumors there might be cell lines that are derived, but the majority of what we have in our collection that are derivatives are the isolates, the bacteria, the viruses that have been grown from these specimens. And in those cases, we would also like to be able to trace them back to the human specimen from which they were originally isolated to be able to close that loop and know where everything came from. How these specimens are used, I think some of the presentations you've heard over the last day and a half of showing you that there are two basic approaches. The so-called research versus non-research use. The purpose of research is, to put it as simply as possible, is to create generalizable information. For example, information that could be applied to create a vaccine policy to say which age groups need to be targeted. As opposed to non-research use which is often for treatment of a specific patient or to identify an outbreak in a particular community. It's more tightly focused. But obviously there is going to be some overlap between those two situations. A non-research specimen could eventually find its way...could eventually be useful in a research project that looks for a prevalence of that same disease nationwide, for example, or to pull it into some sort of international database. But generally those are the two ways we try to differentiate them because the two types of research

are handled differently. Non-research dealing with a public health emergency often has to be—the decisions have to be made quickly. People have to be gotten to the site of the outbreak to be able to act quickly to try to determine what it is and how to stop it. But all CDC activities have to be reviewed whether they are research, and if they are research involving human participants, they go through an additional level of scrutiny. I think a lot of you are probably familiar with the concept of institutional review board. The purpose of an IRB is to have a formal review mechanism to look at not just the way the human subjects are treated but the ethics of the overall research itself. All CDC-conducted activities that are covered by the human research regulations have to be reviewed. They have to be reviewed before the project is begun if it's a research project and they have to be continually reviewed at least annually as the project is ongoing. One of the reasons of this is to ensure that the research involving human participants protects all the rights and welfare of the study participants and conforms to all U.S. regulations. Now, the members we try to pull into these IRB's are obviously subject matter experts but they're also people who are conversant with issues that might arise that don't fall within the usual scientific disciplines of CDC such as ethics, cultural diversity, and CDC makes it a point to have at least one non-CDC member on every board. The board cannot convene unless it has a non-CDC member on it so it's not us approving our own stuff and saying that we're doing it right.

To give you an example of some of the uses that these specimens can be put to; I chose two particular examples. One was an investigation that was done during the 2009 influenza pandemic. A study was done in the Southwest, primarily in the Four Corners area, looking at the effect of the pandemic on especially the more rural populations among the American Indians there. It looked at both clinical and demographic information including the medical records of people hospitalized for basically a three-month period right at the beginning of the pandemic when the first wave was hitting the country. Infection had to be confirmed which means the specimens had to be obtained from the patients. These were usually nasopharyngeal swabs. They would also take convalescent serum to look for antibody. This was used to confirm whether they actually had influenza virus or not because obviously there are a lot of things that can cause similar symptoms. In the case of children, adults gave verbal consent for any child under 18, but informed consent was asked for every participant in the study. Some of the results that came from this were very useful for our future planning. It was discovered, for example, that the hospitalization rate among this particular isolated community was higher than what we'd been seeing in the rest of the U.S. population and that almost all of those hospitalized cases had other high-risk health conditions. One thing that particularly stood out was that children less than five-years of age hospitalization rates were especially high, much higher than the national data. What we took from this was that in planning for future pandemic responses, we have to pay special attention to these types of populations that are in isolated rural areas that are especially vulnerable, so they're going to have to get special attention when making decisions about deployment of drugs from the Strategic National Stockpile or from decisions about how to initiate vaccination campaigns when those are begun.

Another example is the Alaska Area Specimen Bank. Dr. Hennessy talked about that some this morning but that's one of the major success stories being run by the Arctic Investigations

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Program, National Center for Emerging Zoonotic Infectious Diseases. This one is actually a partnership with the Alaska Native people and the intention is to specifically benefit the health and well-being of the native people. These are specimens that can be used for research purposes or they can also be used for non-research purposes. It's a very valuable collection that offers a cross-section of the populations in Alaska. It's quality controlled, secure storage, and it's available for approved research purposes that have gone through the IRB reviews like I mentioned. The reason it was set up was to make sure that there was proper management, especially in regard to human subjects review and making sure that informed consent had been gotten from all of the participants. The types of specimens collected were chosen on the basis of the concerns of the communities affected and it was maintained in accordance with the missions of the Alaska Native tribal health entities that are participating in this activity. And needless to say, as other CDC activities, it meets all federal, tribal standards regarding privacy, research ethics and the protection of the human subjects. Some of the things that have come out of this, you heard the presentation about hepatitis yesterday. That was mainly about hepatitis C but he also mentioned that hepatitis B is one of the major success stories. That's particularly true of the Alaska Native population. These specimens in the Alaska Native Specimen Bank were used to show the prevalence of hepatitis B to show that it was a real problem and was used to justify a concerted effort to get as many people vaccinated as possible. And as a result, it virtually eliminated hepatitis B in the Alaska Native population. Currently, it's being used to determine the prevalence of *Helicobacter Pylori*. The reason this is of concern is I think a lot of people have read the literature of it being associated with gastric ulcers. It's also been associated with...long term with gastric cancer and iron deficiency anemia. These are particular problems in the native populations, and using these specimens that have been collected, were able to get some idea of prevalence, whether particular age groups need to be targeted, particular areas need to be targeted. That's the sort of information that can come out of these large scale collections like this. As I mentioned, we have a separate policy for human research protections. This was set up, it actually predated the specimen policy. It confirms the CDC commitment to protect the rights and welfare of all the participants. It also specifies specific roles and responsibilities for all CDC staff and tells them what procedures they have to go through to get approval for use of any human specimens. And I should also note that CDC reserves the option to impose stricter standards than the minimum that are legally applied, and that happens fairly often at CDC because we are aware of cultural sensitivities and we know that the same standards won't apply to all groups. So that is specifically stated in the policy that CDC may have additional restrictions beyond what's legally required. We're going to go into the policy development. I don't know if you wanted to stop for questions there before I turn it over to the next speaker or wait until the end?

Councilman Chester Antone: Let's go to the presentation and then we'll open it up for questions.

Stacy Howard: Thank you. Good afternoon. Lieutenant Governor Keel and Councilman Antone, it's a pleasure to be back before you again this afternoon to discuss native specimens. I know we've been before the members through several meetings and wanted to provide an opportunity this time to really outline to you what our process is, what our current thinking is of the process

for addressing policy requirements specific to managing specimens taken from the native specimens. The CDC policy process was really outlined—I share with you a process that was outlined by CDC’s Office of Associate Director for Policy and you’ve heard from us in prior TAC meetings that the process is pretty generic across any policy development process, but just to kind of put it in perspective in terms of a process that CDC has developed that aligns with what you may likely already be familiar with, it’s a phased approach. And with the first part of the process it’s identifying what the problem is, and the problem—and I use that word very loosely—is really reiterating what you’ve already heard before. CDC has a number of different operational policies including the Specimen Management Policy that was most recently approved and adopted last year, the end of 2013. But that policy is not specific to specimens from native communities. So what we’re trying to do and what our aim is, is to really fill that gap. What are the needs and how can we best address it. The next part of the policy process is analysis of the issues, and during this part of the process we are looking at existing policies, the ones you’ve heard from already. We’re looking at existing laws and regulations to see where there may be areas in which CDC may need to address and move forward in addressing and determining how to best address that. We’re also looking at background papers on the issues relevant to this topic, and you’ll hear a little bit more about that during Delight Satter’s part of the presentation. The next phase of the policy process is the strategy and policy development. And by that I mean that we’re actually writing the policy, what are the policy requirements. We’re also looking at what would be our approach to determining which policy or policies would such policy requirements apply to; is it just one policy, is it a new policy or does this imply based on what the newly defined policy requirements are that it may impact several policies. We’re also looking at during this part of the policy process looking ahead at implementation; what needs to be in place to implement a policy. It’s one thing to have a policy drafted, written, approved, but it’s really another thing to actually put it in practice and we’re looking at how it can be appropriately implemented. Perhaps it may require developing some implementing procedures and we’ll be looking at that during that phase of the policy process. Policy enactment simply means the approval process and CDC’s process is a process in itself. Dr. Shaw mentioned MASO. MASO is the area within CDC, Management, Analysis, and Services Office...Support Office. It’s another acronym. I’m sure you’re on acronym overload but it’s the area of the CDC that is responsible for formal vetting and approval of all agency policies. I know you’re quite interested in the timeline for which such policy will be in place and I’ll speak to that at the end of the presentation in terms of typically how long just that section is in itself. And then also policy implementation. Dr. Shaw previously mentioned the CDC Specimen Policy Board and its responsibilities, and it is the responsibility of that board, just to reiterate, just to ensure that all policies are implemented as they are intended. It’s also looking at monitoring implementation. It’s also looking at conveying back to you how we’re doing in that process. One area that I want to also highlight those crosscutting areas, stakeholder engagement evaluation. You know, policy development process is not really linear. There are several different aspects of policy development that are undergoing concurrently with stakeholder engagement being critical to the success of this policy development process. We’ve been engaging you, we plan to continue to engage you, and we really look forward to continue to hear from you in terms of how we can best proceed with your assistance in navigating through this process. The purpose of this slide is just to highlight to you where we are in the process now.

We've already identified what the issue is that we're actively working on addressing. We are actively in the process now of analyzing background papers, we're analyzing input from stakeholder engagement, we're analyzing current policies that are in place that Dr. Shaw previously mentioned. We're really looking at what are the sources of information through literature review, through stakeholder input that would inform policy development, where are the gaps that need to be addressed, and we're also actively engaged in stakeholder engagement. We're here today to hear, again, from you and that's very important to this part of the process. As I mentioned before, we will continue to communicate with you as often as you desire as we need to as progress is made as we navigate along this process. So with that said, I'll turn it over to Delight.

Delight Satter: Alright let me know Joe, if you can hear me over there. Thank you for providing us the opportunity to present to you and let you know where we're at in the project, what we've learned so far and where we're headed in the future in partnership with you. I want to put this blanket statement out for this project as well as all things at CDC that the CDC does recognize its trust responsibility and government-to-government relationship with federally-recognized tribes, and we are trying to approach this project in a good way under that overarching statement. So, let's see if she can drive. Ok, I first wanted to present to you some of the places that we've been. These are our listening sessions which we've mentioned to you before and our community dialogs. Listening sessions are open at venues like conferences or larger events and a community dialog might be a smaller event where we're just meeting with some elders in one of the communities we happen to be at at that time. These are facilitated by our partners, the Association of American Indian Physicians and Delores Welch and her consultant, Dr. Doris Cook, partner with us on those and help us find communities to partner with. Last summer, we had our first the kick-off was at the Native Research Network Conference. Where were we? Denver. And what was fabulous was that the NRN board not only agreed to provide us time and space for a listening session but agreed to partner with us ongoing into the future on this project and thanked us for coming to them. That's what they've been asking for as a board to help engage federal agencies, academics, and communities. They also gave us an entire day to focus on bioethics and so several of our external experts who help us on this project who are keynote speakers, Bill Freeman, who you may remember from Indian Health Service, Rebecca Tsosie, a lawyer from Sandra Day O'Connor School of Law, for example, Patricia Cochran from Alaska was the facilitator for the entire day, and we had a great learning experience and exchange. Another one was the Association of American Indian Physicians annual conference, and we had great information received from—it was so amazing because we had different generations of doctors and researchers and clinicians and people who had worked on a variety of projects throughout their lives. Judith Cowart-Hollow, Gerald Hill, for example. It was just very diverse. And then all of these new physicians, native physicians, coming in to the scene. And because as you all know I'm extremely cheap, we also do side visits wherever we are so the Denver Indian Center agreed to have a meeting with us and an elders women's group met with us and gave us information and thanked us for reaching out to them while we were there. I say this because it's a warning. Wherever we happen to be going, we will be setting up side trips and we hope that you help facilitate those for us. We work the rolodex wherever we are going. The University of Arizona

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held meetings with us and I'm so sorry, I don't know why this isn't on here but the National Congress of American Indians also partnered with us in the fall. You look at these slides 500 times and you still forget an entire meeting. They helped us and will continue to partner with us in the future with listening dialogs at their conferences and they gave us quite a bit of other help in learning about the process of engagement, so that was really nice as well. And, of course, most recently Dr. Cook and I were invited by the Tohono O'odham Nation to participate in their annual reburial, I have another slide about that in a few secs. We also had the chance at the NCAI meeting, which just happened to be here in Atlanta. We encourage Atlanta meetings because then we can see all of you more regularly. We had a meeting with the Councilmen Chester Antone and Jefferson Keel just to have that chance to keep updated in between on the project, and there's proof of that meeting because we took them to dinner at the Mary Mac Tea Room and they took our photo and it's up on the wall. So we'll go to the next one. You've seen this slide before. This is about stakeholder engagement, what we've heard. We have two different columns here. First one on the left, is what we have heard from you over time over several meetings. That slide is sort of what we've heard from our engagements, from academics, other stakeholders, youth, elders, you name it we're listening. And we've pointed out before that these two columns, they go together. They're related. But different stakeholders have different advice for us. All of this is very helpful and it takes time to be able to gather that information and to get ourselves around the Country listening. Accountability you all have talked about with us. Consent at the individual and the community level. Integrity, honesty, and in listening sessions we hear a little bit different information, tribal oversight and disposal of specimens, the need for more opportunities for education. So different stakeholders have different interests, and of course CDC laboratorians and scientists are stakeholders, too, and they have different viewpoints and we'll figure out how to put all these together. It was our honor to attend the annual reburial at the Tohono O'odham Nation and we thank Mr. Antone for allowing us that opportunity and working with the Cultural Appropriations committee there. For obvious reasons to the TAC members there's not much detail on this slide but we did learn quite a bit. I didn't think that would happen but I looked at Cathy. So TON has years of experience receiving specimens and remains. We kept hearing one story after the other from the Cultural Appropriates Committee; it was wonderful. They told us their experience. They gave us information on timing. They talked about what they thought would make it successful for us and they offered to share over time more information with us to teach us. The community elders shared perspectives on recovering those remains, you know, where they come from, how they are there. We participated in the ceremony and they all welcomed us and they all acknowledged and appreciated that we were engaging them in the early phase of policy development rather than we created a policy and here it is. Then, we heard two other great things. The community elders, at one of those, you know, non-approved luncheons that Chester was talking about, in the beautiful desert they had their whole...these women came and cooked for us all night long so that we could eat the next day. A whole family, children too, they tented in the freezing cold just to be sure we could eat the next day. But the elders asked us to also create training opportunities, student opportunities for learning from us about policy development and the use of specimens in public health. So that was very helpful to us and I have something up my sleeve on that now with the Ferguson Fellowship here at CDC. Alright, where are we going? The list could be forever. These are just some examples of where

we might go, and as you know, where we travel is always directly related to our travel budgets, but we hope to stretch as far as we can. We're definitely going to the 7th Annual Tribal Epicenter Public Health conference in Oklahoma. Tom Anderson was in town and let us know that we could feel welcome to participate at that conference not only on native specimens but in our Data-into-Action training and some of our other activities that you've heard about before, the success stories from Indian Country. And we have begun discussions with Cherokee. Actually, Cherokee was the first tribe to invite us to just come and join them after that NRN conference in Choctaw. And, again, I don't know why Chickasaw is not there because I know he's looking at me right now. But it's meant to be there. And there's a few others. Please do send to Delores Welch or myself upcoming events and conferences as you know about them in your region so that we can be sure to try to get those on the long schedule. Our dear friend, Rex Lee Jim, invited us to come visit with the Navajo Medicine Men and we look forward to that. Now Ramona is helping us coordinate that. So that will be happening in the near future as well. Okay, so that was our visiting.

Now, we're going to talk about our background papers. Through our contract with AAIP, we commissioned four papers in core areas that we needed further information. So these academics did literature reviews for us and write-ups. In your packets under one of the tabs is the executive summary to the four papers. We do have the four papers. They're almost ready and we would be happy to share those with you at that time. But that executive summary gives a nice overview. Professor Teshia Solomon, who many of you know as the former Tribal Epi Center director for Oklahoma, and her colleague, Yamila El-Khayat, did a literature review on Socio-Cultural, we have a typo in here sorry, literature review on Socio-Cultural Factors and American Indian Values of Bio Specimen Management and Policy. That's sort of the cultural paper. The next one by Rebecca Tsosie, who I mentioned earlier, Indian law professor, is on the Collection, Storage and Use of Native American Biologic Specimens, a Summary of Relevant Legal and Ethical Issues to inform policy development. Jessica Bardill, who has worked for NCAI in the past on multiple policy analyses, provided for us Comparing Tribal Research and Specimen Policies: Models and Practices, literally going into tribal policies and review. And last and certainly not least is my dear fellow, Ibrahim Garba. He is not just my dear fellow, he literally is my fellow. He conducted A Survey of International Policy Guidance on Indigenous Specimen Research and Management. Ibrahim was introduced to me originally by Dr. David Satcher, who you probably both worked with early on in the Tribal Advisory Committee, the former director of CDC who is at Morehouse, a college here in town, and I received Ibrahim as a fellow and then we've hired him in OSTLTS to continue the work with us on native specimens. And I'll turn it back over Stacy. She's going to review the timeline with you all.

Stacy Howard: Thank you, Delight. So we included our current thinking on the timeline for developing policy. I know this is a question that has come up from time to time from one TAC meeting to the next, do we have a policy yet. So in explaining to you and highlighting to you what the overall process is, I wanted to put it within context of within each phase typically how long we anticipate that it would take. So problem identification, we've had a number of different sessions with you during the TAC meetings. We know what the issue is, so we can say that we

have- that issue has been appropriately identified and that was last year. We're currently in the policy analysis phase. We'll be looking critically at the background papers. We'll be participating, as Delight has mentioned, through a number of additional stakeholder engagement through the future opportunities as budget permits for us to engage with hearing from you at different venues. We anticipate us...that activity going through mid of next year and I give that amount of time; we have the Specimen Policy Board meetings already on a standing calendar so it's not by chance will this group come together. We have a schedule of meetings. This topic is on the agenda for each of the meetings, different aspects of this topic on each of the agenda for the scheduled meetings, and we anticipate through mid of next year we would actually have finished analyzing the issues and papers that have been put before us hopefully sooner, and if that changes we'll make sure we communicate and convey that to you. Strategy and policy development, as I mentioned before, we're looking at not just the writing of the policy but what approach will we be taking to address those policy requirements through existing policies or potentially new policy, and we'll start that process this year. We've already started taking a look at it but more formally once we have identified those policy requirements and we anticipate having that completed by the end of next year. Policy enactment as I mentioned before is the actual CDC approval process and that process internally takes anywhere from 4-5 months. It is an iterative process so it has to go through all of the Centers and Offices, particularly those laboratories that may be affected by such policy and that process in itself we anticipate that we'll have policy requirements, depending on how the other phases go, completed mid next year and early '17 and it's a guesstimate just based on where we are today. Policy implementation will, of course, follow after the approval of the policy and that's highlighted for mid next year 2016, 2017 depending on where we are in the process. Stakeholder engagement and education is continuous. It started at our very first meeting, Tribal Advisory Committee meeting, and it's ongoing now and it will continue throughout the process as we move forward in addressing specific policy requirements. So I'll stop there and I will turn it back over to the Chairs for questions, discussion.

Councilman Chester Antone: Are there any questions anyone wants to ask? Comment? Mr. Geisler.

Secretary Adam Geisler: Thank you, Mr. Chairman. This is something that I haven't even thought about so it's interesting to see the issues that other tribes, it sounds like, have brought forward on a national scale and I can understand the sensitivity behind this topic. With regards to the policy that you're creating, in the timeline one of the things that I noticed on your list was meaningful consultation on the development, and this will probably be a point of discussion for later on today as well but understanding how that's rolled out on a nation-to-nation basis, and I realize the challenge of that with over 500 tribes in the United States, it's not an easy thing to accomplish which is why number one, I appreciate the time that you're taking in putting this together because my initial thought was four years is a long time to put this together but I want to put forward that I really appreciate the effort that you're putting forward in making sure that this is something that has really been thought through and respecting the importance of it. But I guess what I'm kind of wondering is once this policy is completed, will there then be consultation

on a tribe-to-tribe basis as opposed to just bringing it to the TAC because oftentimes I think that's the confusion. There's advisory committees that are out there all over with federal agencies and they think that because they brought it to an advisory group such as this, that that is consultation and that, in my opinion, is not in the way that I know a number of tribes in California, they really want to have that government-to-government engagement. And it looks like there's opportunity to have that and you've really thought through the national conferences that are going on with NCAI. You set some of the others that are out there as a forum because it is very hard to go to each nation to have that conversation. I guess I'm just kind of wondering how you're going to roll the policy out to complete the consultation on it because you're gonna take this time, put it out there, it's well thought out, you're gonna put it out and then I guarantee you there's gonna be comments that are gonna come back that might have you reflect on that. So I'm just curious about the roll out part of the process.

Delight Satter: Thank you. First and foremost, we hope to...we do go out to La Jolla. There are plans to go to the NIHB spring conference in Palm Springs, Aguascalientes, and then I've told them how to drive from there to La Jolla and to visit with IHB, Geneva Fitzsimmons. But as far as consultation, it's true that we understand that a Tribal Advisory Committee does not replace tribal consultation, so that's not in the plan to avoid an opportunity for consultation by meeting with you all. You all are here to provide us advice in the development of programs and activities. That said, a CDC operational policy normally wouldn't be vetted on the outside with the public. However, Dr. Monroe has had experience with creating opportunities following the Indian Health Service model for engagement and an opportunity for viewpoints, opinion, and consultation through sharing internal policies. It's complex because some matters within CDC don't rise to the level of requiring consultation but that doesn't mean there aren't other avenues to ensure that each tribe had a chance to review it or provide comment. So I guess I would spin that over to Dr. Monroe.

Dr. Judith Monroe: Sure. Thanks, Delight. Yeah, so I think you're absolutely right and we have taken that under consideration. So when the time is right with all the papers being done and all the work that's being done that's taking time, we would- I would envision that we would send out to all the tribes, and we do "Dear Tribal Leader" letters and so forth we send to all the tribes information on this, as well as, the background and then perhaps—and I don't know at this point whether it would be a draft policy for input exactly what we'd be sending but we would send that out long before it has been finalized for input from all of the tribes and we'd give them ample time to be able to respond. And we've done that with some other things here at CDC that worked well when we approached it that way. Does that make sense, because—and just to add to that, recognizing we can't do that just through electronic communication, either. We have to do it through regular standard mail because we recognize that many of the tribes do not have the electronic means to communicate, as well.

Secretary Adam Geisler: Yeah, I appreciate you saying that because my community in particular, our internet comes and goes depending on whether or not it's cloudy outside, and I'm not joking. I guess just to kind of piggyback on what you shared, I think that it's the face-to-face dialog that

is also helpful. Sometimes tribes aren't always in the best position to sit down and write a written response to the information just because that's not how they convey communication amongst themselves from a cultural standpoint and so I guess what I'm getting at is the face-to-face regional meetings where this draft is being reviewed and discussed is really something—it's the way that other policies are being rolled out at least in California and in the way that we work with federal agencies in our region. And then the other piece on top of that is I think and understanding that this is a living breathing policy so that it's not a one-time slam the door, okay we spent four years and we're done with it now. You know, I'm really hoping that there's a next step on that timeline that says, okay, we've tried this for a few years, can we now- let's take another look at it.

Stacy Howard: Right. Thank you. And just to add to that, if you recall one of the slide that has the circle and there was an evaluation component. After the policy has been implemented, let's look at where we are. Is it working, let's evaluate how well it's been implemented.

Delight Satter: There could be some opportunities as well to participate in the HHS regional consultation sessions, and the way that functions is the OpDiv's, the Operating Divisions like CDC, we don't propose topics to those regional meetings. The items for consideration on the agenda are brought forward from tribal leadership.

Councilman Chester Antone: Any other comments? If not, I just want to say a few things regarding the Tohono O'odham Nation's reburial. That's what they call it, but over the years we've had a lot of interactions with the State of Arizona, the museums of the places where the human remains and artifacts are kept and we've had agreements going in and reclaiming under the Native American Graves and Protection and Repatriation Act, and they accumulate. So we store them at our culture center and then every year we rebury them because what people say out there is it kind of affects the balance of life when people aren't made whole and so that is why we do that. We've gone so far as Mexico City to retrieve remains. The Jewish community helped us out there to get into the museums to reclaim remains. So we've kind of had a lot of experience doing that, and I appreciate that the slide only shows where they went, some of the ideas that came from there, but it doesn't show detail for reasons that trust has been built and trust can come down quickly. And so I asked Delight and Doris that we not share the details, but that's fine that we do that because that shows that this process is building from the tribe up rather than what Delight eluded to earlier as we make a policy, we dish it out to the tribes and say what do you think? This way it's the other way but it does take time. It does take time just like the National Institute of Health's guidance document did. It took maybe 2-3 years. At that time, the leadership at the NIH were people that were tasked with that were kind of fearful that they were trying to do something quickly because of the tribes lobbying for that, but at the same time, we're kind of- what if we do something too quickly and we don't have everything in there. So I told them, I said well, when it comes down to it and if there's something that comes up, I made them an offer. I said, I will defend you to take that time to get tribal input because that's what you need and if there's anything that happens, I will stand up and say that we need the time. So it went on but now it's done so now they're going to move forward on that committee. And I think the same

kind of applies here because we really do need that time, particularly with this topic. I don't know about other tribes how they choose to handle the specimens. Some may probably not want them back, would probably just as well have them disposed, but for us, it's a different thing. That's why I ask these guys, why I invited them, too, and I asked the Cultural Preservation Committee of the Tohono O'odham legislative council would that be okay, and the medicine lady was there and I told her about the reasons why I want them to know the way we see things here because when they start writing, I want that to guide them in part. That's why it's like a personal thing and so they said that it would be alright. That's what we need. We need people to come here and see us, and we want that to happen because we want part of that protocol to be – to recognize how we feel, the respect we feel to our human remains. So that was the reason why, to help guide the writing of that protocol to show some respect to the deceased. So there's a lot of things we still need to answer over there. It's not done, it's not a done deal because we really do need to take that into consideration. But the overall thing is making the person whole again otherwise they're missing something from their previous life. We like to make them whole. So anyway, that was the whole idea behind there and I'm glad that these folks that are doing the policy are taking this into consideration and not doing the detail, but I will tell you that they did help...they did help rebury some of those remains with us, both Doris and Delight, and it was really something. The only thing was that some of the elders were saying, are we now allowing white people to come into the—I said, no, they're tribal members. And I explained to them they're here because I want them to know what we do here because these guys are charged with writing a protocol from a federal agency and we never really ever get the opportunity to inform that policy but now we are, so it's important. And so I just wanted to, you know, share that much with you, and I appreciate the work that's going on. But the only thing is I know all this stuff that you've got to jump through CDC processes and I have in my testimony that there seems to be a lot more emphasis on the process and policy here at CDC than it is with the native specimens protocol. I don't know if you know what I mean but it exists and you have to accept it, I guess. But it kind of takes priority over what we need to do. But if we look at that process as time consuming, it's the same thing as giving time for input. So I guess either way it just depends on how you want to look at it. So we are two minutes over this time. And I don't know if anyone has any last comments but if not, we'll go ahead and excuse the presenters and I thank you very much. Ramona?

Ramona Antone-Nez: Thank you Mr. Chair and members of the CDC TAC and federal—thank you. I just want to say that this dialog has been taking place for over a year now, perhaps a year and a half and what I'd like to do is go back to my community and just really just develop a... propose to my tribal leadership to develop a position paper on behalf of the Navajo Nation. Part of what you have in your slide to come and visit the Navajo Nation Medicine Men, I would also like to touch base back with Vice President Rex Lee Jim about that. The concern that I have is that even among the Navajo, there are different practices of how we take care of specimens and how we take care of this very sensitive topic, and my concern is that when you...if CDC were to come and be invited and actually be in and amongst our medicine people that you might have only one perspective of that diversity within our community from our communities, and even then, it may or may not have that representation throughout what this policy is about. The policy that I thought we were looking forward to or working to build is what is in the current CDC bank right

now as it relates to specifically the American Indian/Alaska Natives that are there historically. And I thought that was the initial questions about what is CDC gonna do about those specimens. And then that is historical collections. Now the question is about what is the current, the most recent, and then now current specimens that might be collected. I don't really, I don't know about all that part there but I would like to take that opportunity to address this within our Nation and get back to CDC. I would like to have that as a self-call to action that this be done at Navajo Nation. At this time, that's what I'd like to remark in terms of just stressing that there is great diversity within our own community and to be—I respect that the Tohono O'odham had invited the CDC to come in and observe and be part of a ceremony, and that's where I would like to protect the Navajo Nation. I don't think it's necessary that CDC start coming in and be part of those ceremonies or these rituals that we have. But of course, as I stated earlier, that would be where I would want to involve our tribal leaders on that as well as our medicine people (speaks in Navajo).

Councilman Chester Antone: Thank you, Ramona, for that comment. Are there any other comments?

Secretary Adam Geisler: I probably sounded really outrageous when I said I'd never thought about this before. The repatriation components—we have the same thing between the Luiseño people. Some believe in repatriation and some believe that you leave it where it is; you leave it, you don't touch it, you shouldn't build over it, you shouldn't move it, it needs to be there, it was placed there for a reason and that needs to be respected. But I think oftentimes when you have this dialog, there's a big difference amongst Indian people, I think, in what we view as significant and I think its terminology so the collection—a policy that you're developing in terms of a collection of a stool sample as opposed to the collection of remains is two completely different things to me in the way that that's being viewed and so I just wanted to clarify my previous statement that repatriation is a huge issue. UCSD is holding several bodies that should be returned to the Kumeyaay (Kamia) people in San Diego County and it's outrageous that they haven't released those and we've been fighting that fight for years and I'm sure you're well aware of in your relationship with Ms. Fitzsimmons. So I guess as this rolls out, I would really like to understand the differentiation between those things.

Dr. Michael Shaw: If I could say something, one of the things that would help us tremendously is to know what sort of specimens you want to know about. I mean, I can understand you wouldn't want to know every urine specimen we have, every bacterium that was grown. It would be very helpful to us if we knew what we're looking for.

Secretary Adam Geisler: So I guess I'll speak specifically for my Tribe. When we come across—the things that are most important to us are the specific remains of bodies, so whether it's areas of cremation because that was a large...that was one of the main ways that we would do our doings when people passed, and when you come across hearts and other things where those are the items of importance, whereas I think sometimes... and tribes are going to be very different, every response here is going to be very different. You know, you come across other aspects such as,

like, a bowl. For us, that was simply a tool. For others, you're gonna find that there's more significance to that, and I realize you're talking about specifically human specimens, but I guess for us, that's where I would be coming from. Anything related to the being themselves that made that person needs to be left alone or not touched. So if you have... I think that's kind of the question that I'm hearing and I don't know the background because I haven't been here, but I think the question that was being posed was what do you have here at the CDC in terms of what's being termed as specimens in terms of people. You know, it's one thing if you're growing a cancer cell or something that you've compiled through sampling or swabbing people's noses or whatever. It's another thing if you're actually holding on to the remains of people as opposed to things that are just daily functions that come out of people.

Dr. Michael Shaw: Well, I can assure you we have no human remains. We may have tissue specimens like from a biopsy or an autopsy. We'd have blood and serum. That's where we need the guidance.

Councilman Chester Antone: (Inaudible.) Ramona.

Ramona Antone-Nez: Thank you. I also would like to add that when we talked about—going back to the listening sessions and community dialogs, future opportunities. I'm just gonna put as a reactive concern that if there were a meeting arranged with Navajo Medicine Men, if that could be a fine line of information gathering/research. You mentioned the IRB. Navajo Nation does have a human research review board. The kinds of questions that would be asked in a—I'm just gonna put quote-unquote—"focus group" and the subject are medicine people or medicine men. Then that information that you're gathering and come back to how you're gonna write it up and tell other people about that specific topic is where I would just be very careful about that type of information gathering. And I bring this because there are a number of researchers that come to Navajo seeking information, and there is a process there that needs to be followed. So I just want to put that on the record and have CDC leadership be informed or just aware that, at least specifically for Navajo, those are points of concern and future discussion. (Speaks in Navajo.)

Delight Satter: Thank you, Ramona. It was the Vice President, Rex Lee Jim, who did invite us to come. He specifically asked us about a year ago to consider a trip out there. So our protocol would be to contact him to help us set that up and this isn't a research project. It's information sharing so that we can do a better job at understanding what the cultural and ethical concerns are from different people, whether they're within an tribe or different generations, so that we can do the best job we can do for a universal policy within the Agency. But let me give you kind of a concrete example of how we go about looking for opportunities. After he did invite us, I happened to meet up with Beverly Pigman who is the—what's her title- The chair of the Navajo Nation IRB. Beverly and I have known each other for years since I've had former students who did work at Navajo and just because we ran in the same circles in my old life. And I just let her know about the project and she said she'd be happy to welcome us when we came to the Nation just to talk to their IRB about what their concerns are, what their advice would be to us. Same thing. We plan on...we've already met with Joe Finkbonner to help introduce us to communities that might want to have a

community dialog when we go up to the Tulalip Tribe in Washington State. So we don't... we're hoping that we don't ever break some cultural taboo or information taboo and we're setting up approaches to help us ensure that we don't do that. We don't plan on writing up research articles. We do have a dream one day of writing up the process- that policy process and how our Agency did partner with communities and do the bottom-up strategy, and we think that that may be helpful to other Agencies or other people in developing policies with communities, not just Native communities but community engagement for policy making. But no particular and specific cultural or sacred information would ever be shared by myself or Dr. Cook; and Chester—I guess he's, you know, given us that vote of confidence. But on the other side, we're not pushing either. If people don't feel welcome or don't want to take that risk, that's fine, too. I love the idea of a position paper or perhaps the reports that you all give could have a special section on native specimens and the community's views. That would be fabulous. However, it's appropriate for us to learn about these things we're willing. And then, of course, we'll always hear feedback in the end with the consultation loop as well.

Councilman Chester Antone: So we're a little bit over, 1:46, and we start Tribal Testimony at 1:30 but what I would suggest would be just a little break, maybe of ten minutes because we have the Tribal Testimony the rest of the afternoon. And so I would like to thank the presenters for that very sensitive topic, and we hope we'll see some good results from there. So we'll have a break for about ten minutes and then we'll start with the tribal consultation because that's the only thing left on the agenda.

Tribal Testimony

Councilman Chester Antone: ...feel free to do so. The other announcement I want to make, I know that earlier Mr. Maloney had asked that everyone remain in here when testimony or people are presenting but we're gonna change that directly from Mr. Maloney. We understand that some of you may be catching flights this afternoon and might want to leave, so I would just say to go ahead and do that if you have to and don't worry about being disruptive, we have microphones. If we talk real close to the microphone I'm sure we'll be able to hear each other and won't hear you leave. So thank you. And the way it has been my experience throughout the years here, that when we come to Tribal Testimony, we leave it up to the Tribal Advisory Committee members, the tribal leadership, to bring forth their testimony to CDC as represented by Dr. Judith Monroe; and there are also people here who are authorized representatives of their elective leadership and they will also have the opportunity to address and testify here and everything is being recorded so we can look back on it and be able to call through it and see where things are of major importance and how we need to address them. So at this point, I'm going to go ahead and ask if anyone wants to do their testimony at this time. If you have it, but you can also do it on the fly as we usually do. Cathy?

Tribal Board Member Cathy Abramson: I'll go. I'm going to read my testimony for the Bemidji area. Of course, we say greetings to everyone. Cathy Abramson from the Sault St. Marie Tribe of

Chippewa Indians. And here come... (Laughter.) ...I know what she is doing; she's trying to get in her steps...I figured it out. So I represent 34 tribes in the Bemidji area and four urban Indian health programs residing in Michigan, Minnesota and Wisconsin. I wish to provide the following comments on these key issues, on three of them. Health and wellness in Indian Country. CDC has gathered funding and other resources from across relevant organizational divisions to invest specifically in tribal communities' efforts to address the persistent chronic disease burden. I'd like to acknowledge and express our appreciation for CDC's efforts to reach American Indian/Alaska Native communities through establishing a funding mechanism directly to tribes and tribal organizations known as Comprehensive Approaches to Health and Wellness in Indian Country. Tribes, tribal organizations in the Urban Indian Health Institute are kicking off local and regional activities proposed in their applications while working with CDC resources to design effective evaluation methodology in order to fully communicate program impact to Congress. In the spirit of government-to-government relationships, tribal leaders must also be fully engaged and informed of the progress and impact made through this investment. We are proposing that a standing agenda item be designated for a Comprehensive Approaches update and progress report at each CDC TAC meeting going forward. OSTLTS communication. First and foremost, the first step in understanding how to best communicate with tribes is to hire viable, committed, long-term and inclusive thinking Director of the OSTLTS' Office of Tribal Engagement. Valuable time has elapsed while temporary assignments have filled the position risking the inability to respond to opportunities requiring a foundation of continuity, established relations and issue consensus. Please seek a permanent assignee, hire as soon as possible.

Hepatitis C and TB elimination: Several tribal communities in the Bemidji area have raised concerns about a perceived increase in hepatitis C. While anecdotal reports are valuable in raising red flags, actual data to confirm observations are not clear nor in the absence of data explained. For example, are hepatitis C diagnosis data underreported in general? Are data reported from different providers or laboratories serving the same tribal population not combined to reflect a community rate of disease? Do local healthcare providers in tribal communities receive data reports from public health communicable disease authorities such as states and CDC? In order to address the perceived hepatitis C outbreaks in tribal communities, we are proposing that upon request a CDC EIS officer or other comparable practitioner be dispatched to the tribal area to support the work of the respective Tribal Epidemiology Center to establish a hepatitis C registry and conduct an investigation using disease outbreak methodology as needed. From there, work with the community can commence to develop appropriate disease reporting and control measures to identify, treat, and ultimately prevent hepatitis C. And in conclusion, I would just like to thank you for your time. Thanks for listening, and I really thank you for the improved communication and input that we've all worked hard to develop. Thank you.

Councilman Chester Antone: Thank you, Cathy. Is there anyone else that would like to provide testimony? Joe?

Joe Finkbonner: Thank you, members of the TAC and distinguished representatives from CDC. Throughout the day and a half that we've been talking, I think there have been some clear

messages that have surfaced about tribal and CDC relationship and one of those is that tribes desire to have direct relationship with CDC rather than through the trickle down through the states and then the locals. So every opportunity that you have to make that relationship direct I would encourage you to do that. In the past we have tried to make efforts for direct allocation of vaccines and antivirals to the tribes in the case like H1N1 when that was our disease of the day and now we're talking about Ebola and how we deal with that, and while I know that it maybe is less likely that we have to deal with Ebola, knocking on wood, in tribal communities I still think that those are models that we should seek to duplicate for other types of communicable disease emergencies or public health emergencies. And we certainly can't count on states to have that positive relationship with tribes and tribal government; however, I would also urge CDC that every opportunity they have where they're not given the authorization to work directly with tribes to make it known that you're at least keeping an eye on the states that they do include tribes in the resources that they get for the populations that's within their borders. I think those are easy fixes that we can at least deal with in the immediate, whether that be an email or some letters requiring that they're working with all of the communities or other partnerships that they have. I think those are valid ways of at least holding them accountable for working with tribal populations. Second, I would like to also encourage you to nudge those other Agencies, like IHS, to make Tribal Epi Centers permanent. It is currently very well received and very well respected in terms of what Tribal Epi Centers can do for the areas; however, there's always that fragile relationship that when it comes to cutting within the Agency of IHS that everything is on the table. But if we can make Tribal Epi Centers something that sticks around, that gives us all in public health a conduit to work with tribal communities specifically on an area-by-area basis.

Second is that I'm disappointed that the Injury Prevention Program is going away. I think that in one of the most disparate areas are motor vehicle accidents and to have a program like Injury Prevention that specifically addressed that in Indian Country I think was valuable, and as we saw from the numbers it was making a difference and we just need to constantly look for ways that we can address those "winnable battles", to use Dr. Freiden's quotes, and I think injury prevention through seatbelt utilization or other things are those winnable battles that we can all package up and implement in all of our communities. Oh, I know there was one other thing. Public Health Infrastructure and the NPHII Grant disappearing. I was disappointed to hear that disappear as well. I think that in the future with the—and I'm saying this from my experience with public health accreditation, I think that is becoming more mainstream and that it is going to be more everyday language for folks is that public health, whether what jurisdiction it is, is going to be either seeking accreditation or has been accredited, and whether tribes choose to voluntarily enter that process or not, I think the three prerequisites of a community health assessment, a health improvement plan, and a strategic plan are valuable to any health jurisdiction and certainly would benefit tribes in terms of the developing intervention strategies to address their own health status. And the other aspect of public health accreditation that's vitally important I think with any system is the performance improvement aspect that's stressed in accreditation. I think that where CDC has opportunities to develop programs working with tribes on that system improvement, whether that be QI or any other type of science that would

help with performance improvement, I would welcome that and I certainly would seek to make sure that was successful in Indian Country. So thanks for listening.

Councilman Chester Antone: Thank you, Joe. Is there anybody else that wants to present their testimony? I'll go ahead and present mine. It is my written testimony but I'll go ahead and go into the other stuff that I've been jotting down as my memory was being jogged. I have Centers for Disease Control and Prevention, February 11, 2015, Tribal Consultation Testimony, Chester Antone, Councilman, Tohono O'odham Nation. Good afternoon honored tribal leaders and honored guests and Director Freiden and Director Judith Monroe. Today, I am here to put forth a request concerning the development of the Native Specimens Protocol. It would seem that such a task would take some time for tribal input to be accomplished; however, it seems as though the process within CDC is of much more value for CDC. It is understandable, but we are relegated to being a lower priority, and so it is right to form a subcommittee of the Tribal Advisory Committee to help with this task. I would ask that the subcommittee be fully briefed on exactly what those that are working on this inside the CDC are doing and what these processes are. In this way we can be able to create this Native Specimens Protocol.

ATSDR should have our native presence there. Lately there have been concerns coming from Indian Country regarding mine operations on tribal lands. Concerns for safe drinking water and for contaminated water and soil has been brought up before in previous consultations. I believe that these concerns should be addressed as best as CDC can and the Tribal Advisory Committee as well. Request for health studies with regard to mine operations are probably coming in to ATSDR although I am not privy to this information. Throughout the years, there has been increasing concern in Indian Country with regard to this. And this was before I knew Annabelle had transferred to TSU, the whole Tribe Affairs Office. Behavioral health agenda for American Indian/Alaska Natives is an idea that we discussed at the Secretary's Tribal Advisory Committee in December of last year. This discussion came about when the then Chairman of the Kickapoo Nation, Steve Cadue wrote an email to Dr. Freiden. This was concerning the most recent acts of violence in Indian Country, especially the incident in Washington State and California. This coupled with the President's instructions to his staff that they visit Indian Country to familiarize themselves with the problems that exist there also provided sustenance to this idea. Many of us Indian tribes talk about and do things tribal with the grants we receive, but we oftentimes have to work with strings attached to these grants. In fact, we have to formulate our proposals according to the letter, that of the regulations that are attached to those grants. There does not seem to be any recognition of tribal ways that could benefit tribes and the Agencies. As I indicated at the STAC meeting, there should be a Tribal Behavioral Health agenda developed and adopted by the current Administration that would provide a roadmap for the future of American Indians and Alaska Natives. This agenda should be based on the tenets or commonalities that exist with all tribes; things such as creation stories that teach morality and values, traditional and cultural aspects that exist in Indian Country such as the coming of age, how special it is, rites of passage, defining Native ways of worship to the creator. Commonalities exist here. The role of the male and the role of the female, the celebration of life, etc. These would define the commonalities that are in each tribe but that are addressed in different ways by each tribe. These are

overarching tenets that would be the roadmap for us. In this way, we define who we are and define our state of well-being in our way. Does CDC have any funds to direct toward this effort such as helping pay for some conferences that would help us define this concept?

CDC's budget has long been a major part of the Tribal Advisory Committee agenda item. This should continue to be a part of it. Where do the funds go? Tribes have always requested direct funding; however, most funds are funneled through the states. CDC's grant management office and the TAC had at one time made a change and required states to provide information to CDC about how those flow through funds benefited Indians as a prerequisite or condition before any funds were released or applied for. I feel that this should be reviewed again.

Fetal Alcohol Spectrum Disorder is another concern to have brought forth. I am glad of the effort that CDC has made as far as information provided, specifically the web page that takes clients into a team setting approach to diagnosing FASD. I feel that CDC should create a more focused approach to the FASD and get TAC input on it. I am also requesting a copy of the cooperative agreement between CDC OSTLTS and the National Indian Health Board, specifically or as well as the CDC cooperative agreement and/or work plan with the Association of American Indian Physicians. Finally, the engagement plan should be more than a plan. It should be actively engaging with tribes and resolve some consultation items. And I thank you and I conclude my testimony for the moment.

Now, I'll just reiterate what I had discussed earlier with the leadership that was here and that is that you heard me speak of the inclusion part of tribes into the overall health system of the United States, and because I see that as access to care for all. That access to care also comes with the other side that is the positive side, but there are other sides that the tribes should really assess themselves on and be aware that there are going to be some changes within your tribal infrastructure. One of them being health transportation services, which we do. We get reimbursement from AHCCCS, which is Medicaid in the State of Arizona. But the access to care also provides transportation services through the form of independent providers, and we have a number of those on the reservation which pull reimbursements outside of the HTS system that we have which was self-sustaining. Now we're in a different situation. So the question becomes access to care, employment, and access to care. So how do we do that because we really need to reassign our drivers if we can or we might be forced to thin out our workforce? So those are the things I just wanted to make sure that we're aware of because those situations will come up, particularly for tribes that have addressed health in many ways and have built up infrastructures but the access to care may change some of those. The direct funding that I had mentioned earlier between the Centers for Medicare and Medicaid Services and Arizona have created this mechanism whereby what the state doesn't fund, the tribes can be reimbursed for in providing certain of those services that aren't available under the state legislation. That was approved, again, December 15, 2014 and I believe they're for three-year periods. So there are ways to do things going around certain things.

One of the key things that's gonna help us here is knowing how far the CDC Director's authority goes as when it comes to budget. What decisions can he make as it concerns the budget with regard to the Indian population? Does he have waiver authority over certain regulations; that is the other part? So we really need to research that so we know how far we can go. The Fetal Alcohol Spectrum Disorder, I had brought that quite a few years ago. Prevention is the key was the outcome of that presentation. So for tribes, exactly how is this awareness service being done at the present time? I made a suggestion earlier that I'm thankful for that CDC had provided us that web page, but when I report back to my council and it goes through all the 12 districts that we have through the legislative representatives, I didn't see the people wanting to get involved in that, and I'm kind of wondering is it our approach...is it our approach about making this information available or do we need more... something more that will generate that interest? And that's just something that we can think about because I believe years ago, I had brought this story to CDC about my niece. She was born with FAS. She was a ranger working for the police department. Now she is a detention officer that tells me that people with FAS can contribute to themselves and to the Nations. It is possible. We just need to figure out a way to get these folks to that point. That was a priority under IHS at one time, the Fetal Alcohol Syndrome as it was called. Now it's Fetal Alcohol Spectrum Disorder and there's only two tribes as far as I know, which is Navajo and Tohono O'odham, who employ people who deal with FASD. So that's prevention certainly, yes, that should be the top priority but we also have to handle those that currently exist. It was a priority back then when it was not a priority anymore. It did not stop the incidents. We just kind of forgot about them, I think, on the national scale for a while. That doesn't mean that there aren't incidents piling up, but somehow I do believe that it has kind of come down. We can see that at different times.

Certainly the Rocky Mountain Spotted Fever in Arizona as I indicated earlier, very difficult to keep making it a priority because of the way it is. You know, you get retested two weeks later, you're positive then. But you've already been given doxycycline that got rid of it but you're diagnosed with—your lab results come in 2, 3 weeks later and you're positive. So it's kind of something that we're kind of having some—we're still fighting it, but it's really hard to go to the communities and say this is where it is. The thing that's really helpful there is thank God we haven't had anyone die from it yet. How far does the authority of the Director extend over the budget and regulations which I discussed earlier?

On our reservation, we're currently developing a food code, and we also have a food policy that has to be backed by that code. So one of the questions that we see coming forward is the feast, as I indicated, where we cook and we feed, but then you bring in our regulatory scheme over that. How is that gonna fly? But that is our problem but sometimes we might reach out to CDC or FDA to see what they're doing on that. Lastly, that I would reiterate is the social determinants of health and you know the story I told earlier that that is really telling when you haven't called the ambulance in almost two years versus quarterly. It really shows that when our... the tribal living conditions are raised to a certain part that it really affects health. It really affects health because I've seen it in my own experience. The chronic illnesses such as respiratory diseases. We told the Department of Homeland Security about four years ago you need to stop patrolling,

61 | 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."

making roads on our reservation when you're looking out for the border because when the wind blows, that dust picks up. They've since kind of stopped a little but not a whole lot. But what happened after that is we've seen less dust, so there are interventions to prevent certain things. Sometimes it requires having to go to where the problem comes from. Oftentimes not in our tribal communities but from another source. So sometimes we need to do that. And I will just reiterate the budget process that we feel that we should be a part of and the key there is figuring out what we can do presently without no new money, and there will be a policy change such as Cathy Abramson mentioned, field officers in the area that requires no new money. It just requires it to be done which will be a policy change, right Judith? And those little ways we can move within CDC, we need to explore that, and for that we need help from the OSTLTS for anybody that has any ideas, and Ursula Bauer, you probably have additional ideas, and I want to thank both of you for being here and the TAC membership and everyone else that is here for listening to what I have to say. And I really think that these items that I brought forth, if we really concentrate to do that, we will certainly be a major step ahead of where we are now. Thank you, and I'm gonna call on Ramona Antone-Nez.

Ramona Antone-Nez: Honorable tribal leaders, distinguished federal officials and guests, it is an honor and responsibility to represent the Navajo Nation at this official tribal consultation session to share testimony and several accomplishments that we have, critical concerns and also provide some recommendations, which pertains to the CDC and ATSDR. The Navajo area delegated representative, Mr. Rex Lee Jim, Vice President of the Navajo Nation, sends his warm regards and regrets that he is not able to attend today's important session. I am Ramona Antone-Nez, (speaking Navajo). I am Navajo and Iroquois Oneida. I'm originally from eastern Navajo. I direct the Navajo epidemiology center and currently acting Executive Director for the Navajo Department of Health, and it is my privilege to be here as a Navajo Nation authorized representative. I want to build upon testimonies that we have provided in years past. One is the Navajo Nation is building our public health infrastructure system to become a state-like health department, as well as, a Medicaid system. I am pleased to report that after years, possibly decades, we have now passed legislation with our 22nd Navajo Nation Council to become a Navajo Department of Health. This legislation is CO-50-14, and it was signed by the Navajo Nation President on November 6, 2014. The significance of that is that it establishes the Navajo Department of Health as the lead Agency delegated to ensure that quality, comprehensive and culturally-relevant healthcare and public health services are provided on the Navajo Nation. It specifically not only changes the name from the Navajo Division of Health to the Department of Health, but also it has such powers and authorities to the Navajo Department of Health. To name a few, is to monitor, evaluate, regulate, enforce and coordinate health codes, regulations, policies and standards that provide public health services in order to protect the health and safety of the Navajo people and communities. There are certainly additional powers and authorities; I will not go through them each; however, what I want to stress there is that the Navajo Department of Health certainly has our work cut out for us. It's something that we have spoken of now and we have wished to become, we are so now. Therefore, we have our work and we look forward to the collaboration with CDC to assist us in this transformation.

I also want to reiterate additional items that we had talked about earlier today, and one of them is the ATSDR. It has been mentioned the Navajo Birth Cohort Study, we are at the latter part of the study; however, there is a need to continue this. Now there is tribal testimony that is available for a long-term study and my understanding is that the funding has been reduced, and we'd like to ask that if there are- there's any ways that we can continue to study and increase funding which has been cut to another level, that would be a request. The other is the National Environmental Think Tank. I'd like to thank the ATSDR for allowing that to happen and I'd like to see activities continue because as mentioned earlier, there's a great need and a great correlation and inter-wovenness between American Indian/Alaska Native health status is as it relates to our environment in which we live and operate. I also want to bring up public health emergency preparedness. I want to thank the CDC that there is a protocol that is in place for Ebola, for providers that are returning and also travelers that return to the United States after travel. We are using that as a guide because, as you know, we have health providers that are on Navajo that have also gone to serve with the Ebola crisis and outbreak that's taken place. Some of the concerns that we have is possibly the misconception or the communication and education about when they return and the possible exposure and risk factors that come, and that is something that we're dealing with in terms of health education and preparedness.

I always will continue to advocate for direct funding. The reason for the direct funding, and I know we've been told that it has to do with better coordination, coordinate with the people that are around in the states of Arizona, New Mexico and Utah. The issue that we have is jurisdiction. This is the reason the Navajo Nation continues to advocate for direct funding. We have a line that separates us and yet we don't see those boundaries within our communities. The boundaries of the Navajo Nation is such that it becomes a jurisdiction issue and we just ask that that would be part of what we continue to work towards. Because we have different funding sources on one item, in this case public health emergency preparedness, the State of Arizona Department of Health has agreed to become the sole grantor, or receive the grant, and then they will send it to the Navajo Nation. There you go. Another example of how the monies are split along the way, and of course as it's being distributed along the way till it finally reaches Navajo Nation, then people have taken their IDC cuts along the way, administrative costs along the way, and so the question is are we using our money effectively?

The other issue that I want to bring forward is Navajo Nation had requested for results for the veterinarian and livestock program. We had sent reports of sera samples, and I just want to close that item right there because we have received the results. Thank you. That makes me a believer that tribal consultation and testimony is effective and it can work. So just a really great thank you for that because we are very curious about the results of those sample, and we've received the results.

About Tribal Epidemiology Centers. I will continue to advocate that they are recognized as public health authorities and also need access to data not only from the CDC but all data that's under the Secretary of Health. As we continue to work for relationships and building those relationships that is a need where that path needs to be developed. I also want to reiterate the request of

Career Epidemiology Field Officers. From my view, I think it's very possible, how can that mechanism be put into place, and it would really support the infrastructure and capabilities of the Tribal Epidemiology Centers to allow for improved health surveillance and monitoring.

I just want to also iterate the importance of partnerships with NIH and also SAMHSA for various reasons. I'm not going to go into whole details but to say that mental health is a huge issue that we face on the Navajo Nation, and as related to alcohol. Chairman... Councilman Antone talked about social determinants and that's part of the root cause that we have is alcohol and how do we address that. It just has many contributing factors to many of the other health conditions that we face on Navajo. I want to iterate the importance of injury prevention. When we talked about mortality rates, the number one mortality on Navajo is unintentional injuries as it relates to motor vehicle and also pedestrians. So it's important that we have that and I just want to thank Ms. Billie about her presentation and just remind that we'd like access to how other tribes and nations are using their activities and scope of works to address alcohol prevention.

I would also like to reiterate about the budget. It has come to my attention that the budget priorities that are identified through CDC is very important; the budget proposals. I'd like to see that we, the CDC TAC, become more involved in that process, and we could build a mechanism of perhaps that would be somewhere we start to put into the charter perhaps, but I would just like to see that we become more involved in that and make recommendations to how the different Centers can use their discretionary dollars. And I'd like to say thank you very much to Dr. Bauer for how you have taken the leadership to use discretionary dollars to disburse dollars and make available to Indian Country, specifically through the Tribal Epidemiology Centers. I have full confidence that when this process evaluation continues to take place 2, 3, 4, 5 years down the road that this is gonna be a really effective model of how we build these types of relationships you have for that. Lastly, the NPHII grant. We were one of the recipients. The value of that is although the grant has ended, the cycle has ended, and we have learned the importance of public health domain and the standards. As it relates to the law that I had talked about earlier that now we're a department of health, we're using that as part of our function and how to operate and manage and build the Navajo Department of Health, as well as we will continue to work towards accreditation readiness. That's a huge process that we have been undertaking and I just want to make testimony that we are working towards that. The Comprehensive Health and Wellness grant, we thank you for the opportunity to join this particular grant and look forward to building that partnership. At this time I just want to say my closing remarks are that under the leadership of Dr. Monroe, I just want to say thank you and I will provide our written testimony, and just want to thank you for your commitment to consult with tribes on our programs, policies and related matters that affect the tribes like you have.

Councilman Chester Antone: Mr. Flying Hawk?

Chairman Robert Flying Hawk: (Speaks Native language.) Thank you, friend. I just wanted to say that I come from the Great Plains Area and my last name is Flying Hawk. And I greet each and every one of you with a heartfelt and happy handshake. And I'm talking about our children. We

do have something written that addresses our children who are our tomorrow and the children's mothers. We consider them the rock of our communities, of our life, and that is what we're talking about here. So I'm going to invite Ms. Giroux up to read what we have addressing this at this time. Jennifer?

Dr. Jennifer Giroux: This is the Great Plains testimony for the CDC Tribal Consultation, Robert Flying Hawk, Chairman, Yankton Sioux Tribe, February 11, 2015. Thank you, Dr. Bauer, for your commitment to integrating tribes into the work of the National Center for Chronic Disease Prevention and Health Promotion, and providing models to other Centers. Excuse me, I'm not used to doing this. Please continue to fund Good Health and Wellness in Indian Country, Partners In Community Health, and Racial and Ethnic Approaches to Community Health. Public health research has led to the understanding of toxic stress and adverse childhood experiences on lifespan, morbidity, and mortality. Northern Plains' tribes experienced the highest chronic disease mortality rates of any racial group in the United States. In order to turn the tide of this generational experience, we need to focus on prevention. We need to go upstream and address preconception health in pregnancy. We need to know and understand what's happening during these most important times. We commend the work of the Reproductive Health in conducting the Pregnancy Risk Assessment Monitoring System in tribal communities, PRAMS. We appreciate the findings of the CDC's Adverse Childhood Experiences, ACEs, study and see the strong correlation with historical trauma, as defined by Maria Yellow Horse Brave Heart. CDC funded the Yankton Sioux Tribe and the Northern Plains Tribal Epidemiology Center to conduct the first tribal PRAMS. We need ongoing funding for subsequent tribal PRAMS. We need assistance with translation and facilitation of community responses to that data. We would like to conduct an American Indian ACE study. Few CDC education prevention dollars distributed through cooperative agreements and grants to state health departments make it to tribal communities in North Dakota, South Dakota, Nebraska or Iowa. We need direct funding for education and prevention dollars that are associated with the results of the data. We need education and funding to inform and re-educate tribal communities on how historical trauma, toxic stress, ACEs inter-relate and we need evidenced-based practices to offer women and babies healthier environments. Thank you.

Councilman Chester Antone: Thank you. Is there anyone else? Delia?

Tribal Council Member Delia Carlyle: First of all, thank you again. Delia Carlyle from the Phoenix Area. This will be my first time providing testimony, so I'm hoping that you all report back to the Phoenix Area tribes that I did okay. If not, they'll probably let me know. I won't go into a lot of repetition because I think a lot has been said prior, whether it's with funding, epidemiology centers, Intertribal Council was one of the first that was funded, one of the first four. They're doing great work and it's still sad knowing that funding—I'm sure all the Centers have provided great information on the works that they're doing out there, but it still doesn't seem to be enough when it comes to funding. So I'm hoping that it will be really looked at. Chester, Chairman Antone, mentioned the Rocky Mountain Spotted disease and we have that. But I'd like to speak on something specifically that they had asked...I was asked to mention. For 32 years, the Inter Tribal

Council of Arizona, Tribal Water and Waste Water Operation Certification program has been continuously supported by a multi-year block grant program from the Department of Health and Human Services, Administration for Children and Families, Office of Community Service, Rural Community Facilities grant program. The ITCA Tribal Op-Cert program averages an annual budget of \$800,000. However, over the last four years, the funding has been continuously reduced. The ITCA Tribal Cert program has been supplementing its program budget shortfalls with small short-term grants, competitive grants from the U.S. Department of Agriculture. The ITCA Tribal Op-Cert program currently is in its 5th and final year of the DHHS block grant. There are indications that the DHHS RCF funding program may have FY 15 appropriations to open another grant at least for one year. However, President Obama's FY 16 budget has the DHHS RCF funding program listed with zero funding. State Operator Certification programs are supported in part by an annual set-aside that is part of the state revolving fund under the Safe Drinking Water Act. The Safe Drinking Water Act has a tribal set-aside but it does not include a set-aside for Tribal Operator Certification program. ITCA continues to engage the U.S. Environment Protection Agency, both headquarters and regional offices, in discussions regarding the funding disparity. In November of 2014, ITCA presented this issue of funding disparity at a meeting of the National Drinking Water Advisory Council in Washington, D.C. The council was unaware of the funding disparity and expressed concern and desire to further investigate the matter. ITCA is attempting to schedule follow-up meetings with EPA headquarters for the months... this February and April of 2015, and since its inception, the ITCA Tribal Operator Certification program empowered more than 600 tribal personnel nationwide ensuring that they have the knowledge, skills, and abilities that are necessary to operate and safely maintain the drinking water and sanitation infrastructure of their respective communities. My tribe opened up a new multi-million dollar waste water facility and has been visited by many tribes to see its operations, and we could not have had that done without the support of ITCA's Water Certification program. So, again, good drinking water for our communities is vital but yet, again, it somehow seems like it's not vital enough to keep funding going. And also in part of the area report, and I was asked to reiterate the same thing about budgeting, to please include tribes whether at the TAC level, CDC TAC level. I think someone had mentioned before, because we don't want to receive a budget that says here it is and we had no input in there. Just the same with the policies. Again, don't want to get a policy that says here it is, and we were never involved. So, again, I only reiterate what was eloquently spoken by the ones previously before me as we continue to work together. Just in the short time I have seen or heard of the changes that have been made and I think we can just make them even better by that commitment of true collaboration, cooperation and coordination. Thank you.

Councilman Chester Antone: Thank you, Delia. Is there anybody? Mr. Geisler?

Secretary Adam Geisler: (Speaks in Native language.)My name is Adam Geisler. I am from the La Jolla Band of Luiseño Indians. I serve as the Secretary for my tribe. I've been asked to represent my tribe on behalf of—in addition to the Southern California Tribal Chairmen's Association, which is a consortium of tribal leaders in Southern California totaling 18 tribes. California holds the largest amount of both reservation and urban Indians in the entire country. My reservation in particular resides in the county that has the most reservations than any other county in the

United States. I want to thank Dr. Freiden, Director Freiden for the foresight and understanding to create a body such as this, such as the TAC. I want to thank Dr. Monroe for the time put forth in coordinating the efforts that have gone on over the last two days. And obviously, I want to thank all of the deputy directors that have spent the time to discuss various topics previously to this consultation session that is being documented.

Through the discussions that have taken place, I find it somewhat ironic that the history of an organization such as the CDC comes from the result of pandemic outbreaks that occurred affecting large amounts of people, and I think when you look at the history of Indian Country and the United States, the need for direct services dating far back to colonization is something that the assistance of the CDC really would've been great at those times as smallpox and other things were presented into our communities. And I think that it is even more interesting that as time has evolved, we are in a situation where we were left out from the beginning, exterminated as a result, and now we are at a point in our history where we are seeing a need for collaboration and coordination to protect the health and safety of our families and of the children of our communities. With that being said, I think that it is not unreasonable for tribes to expect to have a seat at the table in a budgeting process when they should've had a seat at the table for many, many years since the inception of this organization. The fiduciary trust responsibility of the United States government is something that many tribal leaders will speak about but the reason why that is always brought up is because the situation in which many tribes are in is not something that we chose, and the political nature is the result of treaties and executive orders that have come out of the creation of reservations, Rancherias and other forms of trust holdings, are something that we have had to live with, with an understanding that there would be support from the federal government and the agencies underneath. The inclusion in the budgeting process is something that tribes may ask but I'm going to make a formal demand that we be included both in the general budgeting process but more importantly as it comes down from the deputy director engagement. I find that the challenge in being able to compete for sources of funds when they're coming through state agencies is challenging as most tribes have never been in a financial position to be able to have the resources to collect the information, and oftentimes that information is not making it into state agencies so the CDC is able to make a fair assessment of the data that they're trying to review. I also feel that the need for an annual report coming from the CDC regarding issues related specifically to Indian Country on an annual basis is a tool that tribes need in this Nation in order to better understand where the CDC is coming from and what you're seeing so we can have a more informative dialog in the development of solutions and mitigation to address the issues that are out there. I will take it one step further in looking at the most recent allocation of funds for the Ebola outbreak. The irony that exists in a \$1.8 billion allocation of funds to—and I do not mean to take away from the importance of the matter or take away from the severity of the fact that people are dying in other places around the world and the potential impact that goes on around the world as a result of such a disease, but I would also like to point out that we have seen documentation in the last two days that shows evidence of very similar things happening here in Indian Country with relationship to Hepatitis C. And when I look at the correlation between the two statistically, I think that the impacts, if you looked at the data, would show that the number of people affected might have some parallels, and as such,

I realize that there have been policy discussions or legislative reasoning behind the justification as to why additional services can't be coming to Indian Country, yet I find that there is allowances under other circumstances that permit such actions to be occurring. Obviously, in speaking generally, because I want to be clear that I'm speaking on behalf of my tribe, that this is being considered as formal consultation, I want the CDC to understand that the diversity in Indian Country is great and that when you try to have a conversation with a large land-based tribe, there is a large difference between the capabilities between the Nations. Ideally, the idea of tribal sovereignty is to reach a point where we don't need the help of anybody else, and that is what I think Indian tribes are striving towards. I know that that is what my community is striving towards because that's the ultimate of exercising your sovereignty as a nation. But with that being said, tribes in California tend to be smaller land bases making it more challenging for us to have the types of facilities that you might see with other tribes throughout the United States. And with that being said, that impacts the number of programs and resources available to community members within our communities which is why, again, I will advocate for increased funding and looking at tribal-specific programs because it's hard to hold our own in a state like California being the size that we are in terms of the competitive nature of funding mechanisms that are coming down. Obviously, a large portion of this statement is coming from a financial perspective, and with that, I want to add two more recommendations to the CDC. One is a request that the CDC use a portion of the 37 million increase in the surveillance epidemiology and public health informatics line item to support the creation of data collection and storage systems within the existing Tribal Epidemiology Centers. I realize, and I would like to state for the record, that this has been stated multiple times, but I also feel that the more we say it, hopefully the larger the impact will be, as I realize we are trying to represent ideas from different regions. The second is that we would request that a portion of the \$15 million increase for public health workforce capacity support efforts to bolster the tribal public health workforce through innovative training at tribal colleges and universities as well as dedicating specific CDC fellows to serve in Indian Country. The preparation of our youth to take on the challenges as we grow our Nation's capabilities in this area of study regarding health is a priority. Representing the people of La Jolla, I know that we are always looking for opportunities to grow and educate our youth, and the more that CDC can offer the programs, and I want to acknowledge the different programs that have been discussed over the last week and I think it's a great starting point, but the more that we can encourage opportunity for our youth to come out and understand how this impacts their communities, I think the better we'll be prepared to address the various challenges including the mental health components and suicide prevention issues that a number of our communities are continually facing. In closing, I again want to thank the TAC and the leadership that has been brought forth on the tribal side from Tohono O'odham. I also again want to thank Dr. Freiden and Dr. Monroe for understanding the complexities of Indian Country and being willing to work through the issues. I specifically want to thank Dr. Bauer for the time and effort that she has put forward in understanding the needs of Indian Country and trying to address those. And lastly, I want to thank the TAC membership that is here. It is an honor to be sitting here with you, and I thank you for sharing your time and your leadership with myself and my tribe. (Speaks in Native language.)

Councilman Chester Antone: Thank you, Mr. Geisler. Anyone else want to provide some testimony, comments? Are we all out of things to say? If we don't have anything else, I think this is our last item on our agenda, and I really want to thank everyone in the audience on both sides. I want to thank the leadership that stayed for this afternoon to listen and I appreciate your presence here. And I would ask Judith to convey that to the directors and the deputy directors that were presenting this morning. I know they all have things to do, but we appreciate their presence for the time that they were here to listen to us and to respond to certain questions that were asked of them, and especially to Ileana Arias, I would like to have you convey that to her also for having her directors here and herself, and to give the message to Dr. Freiden that we want to be included in the budget process, and we want to know what his authorities are as far as regulations and line items that could be done. So with that, I would ask Mr. Flying Hawk if he could give us a closing blessing.

Meeting Closing

Chairman Robert Flying Hawk: Again, I'd like to ask all of us again to call on our Creator as we understand him in our own way.

(Blessing.)

Councilman Chester Antone: Amen. Well thank you everyone. I believe for those going on the visit to the Civil Rights Museum, the shuttle will be in the lobby...we will wait for the shuttle in the lobby. It should be coming by 8:30 and then we will go over to the Civil Rights Museum. This is exactly what we are talking about....so 8:30 and we conclude this consultation. It was a lively debate, lively testimony, but for us it's real and hopefully for y'all to consider. Thank you. Would you have any closing remarks anyone? Judith?

Dr. Judith Monroe: Well thank you. Let me extend thanks to you, Chairman Antone, and to our Co-Chairman Keel, for your leadership. I just want to say to all of the TAC members it's been an honor to meet with you over the last two days, and really appreciate your really meaningful and well thought out testimony. So we will take forward all that we've heard to senior leadership. So thank you all very much. And let me...and also a big thanks to Joe and to all the CDC colleagues and staff that made this happen.

(Applause)

Councilman Chester Antone: Joe, do you got anything?

CAPT Joe Maloney: I won't hold anybody up. I'll let Dr. Monroe have the last word. But just the thanks again to the TAC members. You've all come a very long way. You've been away from your tribe and your families and we really appreciate your investment in all this. So thanks again.

Councilman Chester Antone: Annabelle, I'm gonna call on you. I know you have a little something to say.

Annabelle Allison: Thank you, Chairman. I just want to also extend my thanks and gratitude to everyone for being able to come here today. The past two days have been really insightful. We've taken a lot of information; we've had numerous discussions just between us and between the TAC members and my colleagues, and we're really excited about moving forward. I also just want to say thank you for all of your support as I move into this new role. I'm really excited about it and I really hope that we can continue to work together. Thank you. (Speaks Navajo.)

Councilman Chester Antone: Thank you to everyone here, the support staff at the TSU. You guys make this possible from....how do you say that...taking us down to the lunch room....cafeteria. Being all worried for us and what's missing, and what's there? Thank you all. So that'll be it.

END.