



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

**Tribal Advisory Committee (TAC) Meeting**

**January 31 – February 1, 2012  
Minutes of the Meeting**

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**Acronyms**

ACA	Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian /Alaska Native
AIMS	American Indian Multi-State
AJPH	American Journal of Public Health
ATSDR	Agency for Toxic Substances and Disease Registry
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CER	Comparative Effectiveness Research
CHSDA	Contract Health Service Delivery Area
CMS	Centers for Medicare and Medicaid Services
CORD	CDC Online Resource Directory
COSTEP	Commissioned Corps Officer Student Training and Extern Program
CRIHB	California Rural Indian Health Board
FOA	Funding Opportunity Announcement
HHS	Health and Human Services
HRSPC	Health Reform Strategy, Policy and Coordination
HVA	Hazard Vulnerabilities Assessment
IHS	Indian Health Service
IHCIA	Indian Health Care Improvement Act
IRB	Institutional Review Board
ITCA	Inter Tribal Council of Arizona
LSPPP	Laboratory Science, Policy, and Practice Program
MEG	Monitoring and Evaluation Group
MMWR	Morbidity and Mortality Weekly Report
NCEH	National Center for Environmental Health
NCI	National Cancer Institute
NDI	National Death Index
NIHB	National Indian Health Board
NPCR	National Program of Cancer Registries
NPHPSP	National Public Health Performance Standards Program
NPIII	National Public Health Improvement Initiative
OMHHE	Office of Minority Health and Health Equity
OSEL	Office of Surveillance and Epidemiology Labs
OSTLTS	Office of State, Tribal, Local, and Territorial Support
OTA	Office of Tribal Affairs
PGO	Procurement and Grants Office
PHAP	Public Health Associate Program
PHLP	Public Health Law Program
PSAs	Public Service Announcements
SEER	Surveillance, Epidemiology and End Results
STAC	Secretary's Tribal Advisory Committee
STDs	Sexually Transmitted Diseases

STIs	Sexually Transmitted Infections
STLT	State, Tribal, Local and Territorial
TAC	Tribal Advisory Committee
TB	Tuberculosis
TSII	Technical Assistance and Service Improvement Initiative
UNITY	United National Indian Tribal Youth, Inc.
VFC	Vaccines for Children
WHO	World Health Organization

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**Opening Blessing / Welcome**

**Chester Antone, TAC Co-Chair  
Councilman, Tohono O’odham Nation**

The CDC/ATSDR Tribal Advisory Committee Meeting was held January 31 – February 1, 2012, in Atlanta, Georgia. The meeting began with TAC Co-Chair Chester Antone welcoming the participants and inviting Lester Secatero, Chairman, Albuquerque Area Indian Health Board, to give the opening blessing. Chairman Antone then asked that members of the Tribal Advisory Committee (TAC) provide a brief self-introduction, followed by the official calling of the roll by Kimberly Cantrell, Public Health Advisor-Tribal Support, Office for State, Tribal, Local and Territorial Support (OSTLTS), Centers for Disease Control and Prevention (CDC). With a quorum being met (N=10), Chairman Antone proceeded to ask the audience members to introduce themselves. (A participant roster is included as Appendix A.)

**Welcome and OSTLTS Updates**

**Judith Monroe, MD, FAAFP, Deputy Director, CDC and Director, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention**

Dr. Monroe extended welcoming remarks, reaffirming that the CDC recognizes its unique relationship with American Indians/Alaska Natives (AI/ANs) and remains committed to its relationship with Tribal governments. As an agency of the U.S. Department of Health and Human Services (HHS), Dr. Monroe said the CDC recognizes the complexities of relationships with Tribes and is committed to working on a government-to-government basis. After acknowledging the attendance of her colleagues Dr. Gregory Holzman, Associate Deputy Director for Tribal Support, Tribal Support Office, OSTLTS, CDC; and Delight Satter, Associate Director for Tribal Support, Tribal Support Office, OSTLTS, CDC, Dr. Monroe began her presentation on OSTLTS updates. Dr. Monroe said primary CDC activities are to monitor health; detect and investigate health problems; conduct research to enhance prevention; develop evidence to determine which policies can improve health; promote healthy behaviors and implement prevention strategies; foster safe and healthy environments; and provide leadership and training. She showed an organizational chart of CDC to illustrate where OSTLTS is housed, and then displayed and discussed the OSTLTS organizational chart. She made special note of the responsibilities assigned to Ms. Satter as the Associate Director for Tribal Support: coordinate CDC programs and policies that benefit or affect

AI/AN populations; serve as principal advisor and main liaison with policy-level officials; and serve as principal contact for all AI/AN public health activities.

Holding as its mission to improve the capacity and performance of the public health system, Dr. Monroe said OSTLTS touches every health department across the country and has worked to have a more integrated system. Accepting the need to take science and apply it to practice, Dr. Monroe showed a logic model to illustrate her point of translating science to practice and gave examples of communications tools/initiatives currently being employed. Specifically, Dr. Monroe referenced:

- **Did You Know?**—a weekly feature from the OSTLTS to inform prevention activities.
- **Have You Heard?**—CDC's online newsroom.
- **STLT Gateway**—a tool to connect the public health workforce to information, tools, and resources at CDC.
- **Vital Signs Town Hall Teleconference**—a forum for state, Tribal, local, and territorial health officials to discuss important public health issues.
- **NPHPSP (National Public Health Performance Standards Program)**—a National Partnership initiative that has developed National Public Health Performance Standards for state and local public health systems and for public health governing bodies.
- **Guide to Community Preventative Services**—a resource to help users choose programs and policies, that have been systemically reviewed and labeled, to improve health and prevent disease in their community.

Next, Dr. Monroe discussed the Public Health Associate Program (PHAP). The 2-year on-the-job training program places associates at a state, Tribal, local or territorial public health agency to work alongside local public health professionals. She showed a map of where the associates are placed throughout the U.S., noting that three are in Indian country: California, Montana, and Washington. She also mentioned that the CDC hopes to increase the number of hires this year. Dr. Monroe indicated that the application period opens February 1, 2012. She emphasized that the host site needs to cover local travel, have a supervisor onsite, and provide a workspace and equipment for the associate, among other things; and she directed the group to the <http://www.cdc.gov/phap/> website for more information. She said she would need to check if it is possible for Tribes to share an associate.

Dr. Monroe informed the group that CDC is also focusing on field staff, showing where CDC domestic staffs have been assigned. The hope, she said, is to build better support and communications from field staff to CDC and improve support to project officers. She also addressed the National Public Health Improvement Initiative (NPHII), which funded state, Tribal, local and territorial health departments to make fundamental changes and enhancements in their organizations and practices that improve the delivery and impact of public health services. She provided details on the eight Tribal awardees: Alaska Native Tribal Health Consortium; Cherokee Nation; Gila River Indian Community; Millie Lacs Band of Ojibwe; Montana-Wyoming Tribal Leaders Council; Navajo Nation Tribal Government; Northwest Portland Area Indian Health Board; and Southeast Alaska Regional Health Consortium. Among the challenges of the NPHII cited by Dr. Monroe included the anticipation of flat funding and continuous quality of improvement. She also indicated that stories, both stories of success and stories of challenges, are needed.

In discussing the CDC's role in accreditation and quality improvement, Dr. Monroe said the CDC provides support via accreditation readiness resources/tools and supports initiatives through mini-grants.

Recognizing that Matthew Penn, Director, Public Health Law Program, OSTLTS, CDC, would talk about Public Health Law later in the meeting, Dr. Monroe moved her discussion to the Technical Assistance and Service Improvement Initiative (TASII). She explained that TASII is a cross-agency initiative, led by OSTLTS, to enhance CDC support to state, Tribal, local, and territorial jurisdictions. Specifically, she said TASII will develop and enhance systems, strategies, tools, practices, and policies to support CDC project officers and program consultants (and their supervisors) to ensure consistent, high quality project officer performance. Dr. Monroe said the initiative kicked off on October 31, 2011, with approximately 1500 individuals attending the event. After describing the expected benefits to STLT [State, Tribal, Local and Territorial] partners, Dr. Monroe said assistance was needed from them in the form of reviewing an external survey tool, piloting the survey tool, and helping to identify performance metrics.

In closing, Dr. Monroe provided background information on the STLT Gateway. Having had a soft launch in July 2011, she said the Gateway provides a one-stop-shop for STLT public health agency staff to find and connect to CDC content relevant to their work. She also mentioned the CDC Online Resource Directory (CORD) as a tool to assist STLT staff with finding and contacting experts at CDC; and she recognized Diabetes Talking Circles as a best practice approach to diabetes prevention in Native communities.

#### Discussion Points

- Dr. Holzman said an additional OSTLTS staff person was not in place because of budget cuts.
- Chelsea Payne said there was low Tribal participation on town hall conferences.
- Dr. Monroe suggested doing focused calls with Tribes, due to their lack of participation on town hall conferences.
- Dr. Holzman stated that town hall teleconferences are archived on the website.

Before moving to the next session, Ms. Cantrell asked non-TAC members to leave the room.

### **TAC Business Meeting**

**Chester Antone, Co-Chair, TAC**

**Brenda Nielson, Co-Chair, TAC**

#### Roll Call

Chairman Antone confirmed with Ms. Cantrell that the roll called at the beginning of the meeting could also serve as the roll call for the TAC Business Meeting portion of the agenda. Ms. Cantrell noted that Rex Lee Jim, representing the Navajo Nation, was now present and therefore should be included in voting counts.

Approve Agenda**Motion**

Vice President Jim motioned to approve the agenda for the CDC/ATSDR Tribal Advisory Committee Meeting. The motion was seconded by Mr. Butler. The vote was taken. The motion carried with all in favor, none opposed, and no abstentions.

Approve Minutes

Corrections to TAC Meeting Minutes dated August 22-23, 2011, were noted:

- Spelling error on the name Dee Sabattus on Page 17.
- Spelling error on the acronym IHS on Page 9.

**Motion**

Ms. Hilbert motioned to approve the meeting minutes from August 22-23, 2011. The motion was seconded by Mr. Petherick. The vote was taken. The motion carried with all in favor, none opposed, no abstentions.

Summer Meeting Location

Chairman Antone asked for discussion on potential sites for the TAC's summer 2012 meeting. Mr. Petherick inquired about previous locations. Ms. Cantrell responded that the TAC had previously met in Washington, DC; Montana; Alaska; New Mexico; and Arizona. Chairman Antone suggested that the group consider meeting in Wisconsin, because of the various environmental issues there. Mr. Petherick expressed his support for having the meeting in Wisconsin, adding that he would like to get support from the area before finalizing that decision. Ms. Bohlen said she thought there would be support from the Tribes in that area. Chairman Antone asked and received no additional recommendations for alternative sites. Mr. Secatero inquired about the potential date of the meeting. Ms. Cantrell responded that historically the group decided on a location first, and then worked with contacts in the area to set a date. She said the meeting typically occurs in July or August. Chairwoman Nielson cautioned that the north coastal Tribes hold their annual "Paddle" the third week in July.

**Motion**

Vice President Jim motioned to have the TAC summer 2012 meeting in Wisconsin. The motion was seconded by Chairwoman Nielson. The vote was taken. The motion carried with all in favor, none opposed, no abstentions.

Chairman Antone requested that Ms. Bohlen gather information on contacts in Wisconsin and forward the information to Ms. Cantrell.

### Issues to Raise Up to HHS

Ms. Cantrell informed the group that issues raised during this session would go to the STAC. In response to her comment, Mr. Petherick inquired about issues previously raised by the TAC. He was told that Page 7 of the minutes from the TAC's August 22-23, 2011, meeting contained previously suggested issues for the STAC. Ms. Cantrell said two of the primary issues were collaboration and data. Specifically, collaboration and coordination between federal agencies (and between state/local governments and Tribes) was deemed needed to help maximize the benefits from programs that could help Tribes; and Tribes' access to data continued to be a major issue. Chairman Antone suggested that the TAC prepare a letter outlining issues of concern for the Co-Chairs to sign and deliver it to the STAC before its May 2012 meeting. Noting that the STAC had yet to provide a format for submissions, Ms. Cantrell agreed with Chairman Antone's suggestion. Ms. Bohlen asked if the materials provided to the STAC would be the same as those presented at the upcoming HHS Annual Tribal Consultation Session. Chairman Antone said that would be in order, stating that it would be good information to give to all of HHS, as the TAC has presented testimony during that session for the last 3 years. To that end, he asked if the document could be prepared in time. He said the HHS Annual Tribal Consultation Session is scheduled for March 2012. Ms. Satter asked if there were issues that needed to be raised beyond the three items listed in the TAC's previous set of minutes. [The third item was: "The TAC remains in limbo due to the reorganization of the CDC."] Ms. Hilbert suggested that the issue of access to data needed to be expanded, noting that Tribes in New York had expressed difficulty in getting data at the state level. Ms. Bohlen commented that data sharing was a part of the Affordable Care Act (ACA); and Chairman Antone reminded the group that Secretary Sebelius' letter to state governors encouraged them to work with Tribes. Mr. Petherick suggested a need to focus on coordination with states regarding collaboration related to accreditation. Ms. Satter asked if Mr. Petherick was talking about public health accreditation. He responded, "Yes." Ms. Bohlen asked the group to consider addressing potential sequestration issues as a strategy to protect Indian programs across the agency. Ms. Satter inquired if the group was in agreement with Ms. Bohlen's suggestion. Chairwoman Nielson indicated that the group's lack of response meant it was in agreement. Chairman Antone said the suggested items could be added to the list of issues to raise to the STAC if that was the group's desire. Ms. Cantrell indicated that motions were warranted, further commenting that she was willing to work with Ms. Bohlen to draft the language concerning the issue of sequestration.

Mr. Petherick asked if the third bullet, "The TAC remains in limbo due to the reorganization of the CDC," was still relevant. Ms. Hilbert suggested that maybe that bullet could be reworded. Chairman Antone said the reorganization was ongoing for 2 years, but with Ms. Satter and Ms. Cantrell in place the process is moving forward. He suggested that the wording speak to the process continuing to move forward. Chairman Antone also stated that he felt the second and third sub-

bullets were still applicable. Ms. McKinley reiterated the importance of retaining the second sub-bullet. Chairman Antone suggested that the third main bullet from the August 22-23, 2011, meeting minutes be changed to read, “Issues related to CDC reorganization.”

### Motion

Ms. Hilbert motioned to have the three issues previously identified as items to raise to the STAC in the TAC’s August 22-23, 2011, meeting minutes as those that would be raised to the STAC and presented at the Annual HHS Tribal Consultation Session in March. The first bullet on collaboration will be expanded to address a focus on coordination with states regarding collaboration related to public health accreditation. The second bullet on data will be expanded to address access to data at the state level and open dialogue between states and Tribes. The third bullet will be changed to read, “Issues related to CDC reorganization” and the first sub-bullet therein reworded. The issue of sequestration and holding Indian programs harmless will be added as a new item to raise to the STAC. The motion was seconded by Chairwoman Nielson. The vote was taken.\* The motion carried with all in favor, none opposed, no abstentions.

\*Per Ms. Cantrell’s request, an additional roll call was taken for this vote. The following areas were represented in the vote count: Alaska, Albuquerque, California, Nashville, Navajo, Oklahoma, Phoenix, Portland, Tucson, NIHB, and the Tribal Self Governance Advisory Committee.

## **TAC Charter Discussion**

**Delight Satter, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention.**  
**Kimberly Cantrell, Deputy, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention**

**Chester Antone, Co-Chair, TAC**  
**Brenda Nielson, Co-Chair, TAC**

Ms. Cantrell welcomed back the non-TAC participants to the open session, stating that she would provide an overview of the last year’s activities and address next steps. She reminded the group that at the last TAC meeting there was an update on the CDC Tribal Consultation Policy. At that time, she said, Dee Sabattus did a comparison of the CDC and HHS policies and revisions were made. A revised version of the CDC policy, with suggestions and comments incorporated, was subsequently sent to the CDC Centers for review. Centers’ comments have yet to be incorporated; and Ms. Satter has not had an opportunity to read the document. She said they will determine the best course of action, as an office. Ms. Cantrell emphasized that the Tribal Consultation Policy allows the TAC to advise CDC on consultation and other issues. She also indicated that the TAC’s charter was last updated in 2009, noting the importance of reviewing it to ensure it reflects the direction the group was to go.

Ms. Satter acknowledged that there had not been a lot of time to focus on the CDC Tribal Consultation Policy and TAC Charter. Notwithstanding, she said there would be a second opportunity for the TAC to review the documents. She suggested that the TAC Co-Chairs invite individuals to work on an interim committee to assist with the work that needed to be done. Chairman Antone, wanting clarification, asked “Do you need a subcommittee to work on the charter?” Ms. Satter responded, “Yes.” Chairman Antone then asked if the CDC Tribal Consultation Policy was completed or if it would undergo another round of reviews. Ms. Satter remarked that when the Centers received the updated version, it did not include mark-ups. Therefore, she said she would provide that information to them. To that end, she said there is work to be done on both the charter and the consultation policy. In response to a question by Chairman Antone regarding if the version of consultation policy in the meeting packet was a draft, Ms. Satter indicated that the first core workgroup’s comments were included. She reiterated that a marked-up copy wasn’t shared when the document was sent out for review, and therefore she needed to ensure that everyone participating understands what is “original.” Chairman Antone asked for further clarification as to whether the TAC’s comments are included. Ms. Cantrell confirmed that they are, saying that is what the Centers saw. Chairman Antone next asked if the request was to have a subcommittee work on both documents. Ms. Cantrell responded, “Yes.” She also noted that a monthly time commitment would be needed. Ms. Satter expressed optimism that the work could be concluded within 6 months, with both documents being ready in time for the next TAC meeting.

The following individuals volunteered to serve on a committee to assist with finalizing the CDC Tribal Consultation Policy and the TAC Charter: Mr. Petherick, Ms. Bohlen (as a technical support person to Ms. Abramson), Chairman Antone, Dee Sabattus (per Ms. Hilbert’s instruction), Mr. Finkbonner, and Vice President Jim. Ms. Cantrell agreed to contact the volunteers regarding setting up a meeting time to begin the work. She also indicated that updates on their progress would be provided to the TAC during planning calls.

### **Area/Organizational Updates**

Mr. Secatero provided an update for Albuquerque. Highlights from his remarks are provided below:

- Increase in diabetes among adults.
- Navajo Nation supplied trucks for getting medicine and wood to persons in need during periods of heavy snow; and the county provided helicopters.
- Navajo Nation gave \$200,000 to buy medical equipment.
- Working on cross deputizing law enforcement officers with the county and the state.
- County provides assistance to the fire department and ambulances.
- Raised money to build a clinic, but needs additional staffing.
- Will bring in a water line from Albuquerque.
- A gas company that wants to run a gas line through the reservation.
- Immunizations are occurring late, around January.
- Johns Hopkins is doing a survey on Native foods.
- Uranium mine will open on nearby private land.
- Some people bothered by President Obama’s use of the code name “Geronimo” [in reference to Osama Bin Laden].

Nashville representative Ms. Hilbert said she tried to gather information from Tribes in her area for the last 6 months. She apologized to Ms. Cantrell for the brevity of her report, stating that many Tribes were very busy with their day-to-day issues and therefore they were unable to respond to her inquiry. Among the information she was able to glean includes the following:

- Tribes are committed to work they do with the United South and Eastern Tribes, Inc.
- Some Tribes concerned about data collection, diabetes, prescription drugs, bath salts, and substance abuse.
- Tribes are working hard on dealing with alcohol and substance abuse issues.
- A lot of Tribes are working on the SDPI grant and related reporting requirements.

Mr. Petherick's update on the Oklahoma City area focused on:

- Work with Inter-Tribal Health Board and Epidemiology Center to get CDC information disseminated.
- Epidemiology Center Director position now stable.
- Developing Tribal community health profiles.
- Assisting Tribes with navigating through the public health accreditation.
- Working on collaboration, e.g., the Oklahoma State Department of Health has established a Tribal Office. Now a full-time Tribal staff person is dedicated to working on public health issues. They are also working on inter-jurisdictional issues.
- Working well with counterparts at the state level to address emergency management issues.

Mr. Finkbonner cited the following updates for Portland:

- There is a weekly mail out to disseminate CDC information.
- Quality and performance improvement will be important to Tribes, especially as they consider if accreditation is appropriate for them
- HIV/STD programs use media sources to contact teens to get them health information.
- Continue to work on provider development through the Cancer Control program.
- Working with Fred Hutch on the AIMS [American Indian Multi-State] Project—looking at cancer survivors' outcomes.
- Moving forward with the BRFSS [Behavioral Risk Factor Surveillance System] project.
- Would like CDC to continue to foster relationships between Tribal public health systems and states/locals.
- Received feedback that HIV block grants are not making it to Tribal levels.

Ms. Bohlen provided an update on the NIHB. Highlights from her presentation included the following:

- Continues to develop and refine a national list of Tribal health directors and public health directors to disseminate information from CDC, as well as other information relevant to public health.
- Public Health Summit will be May 30 – June 1, 2012, in Tulsa, Oklahoma. Hoping for CDC support.

- Will form a National Tribal Technical Health Tribal Advisory Committee to help in developing policy, providing analysis, and looking at public health impacts.
- Developed a proposal for CDC to support the development of a Tribal Public Health Workgroup to act as an advisory group to the TAC.
- Working with the Tribal Epidemiology Centers Directors Workgroup and will develop a web based fact sheet and will post on NIHB a website list of Tribal Epidemiology Centers with contact information and links.
- Collaborating on two research initiatives: Public Health Systems and Services Research and Health Professions Opportunities grants.
- Working with IHS and the Native American AIDS Prevention Center to develop additional outreach efforts and media campaigns for HIV/AIDS prevention initiatives.
- Board of Directors developed and passed a resolution to create a Tribal Youth Health Advisory Committee.
- Partnering with UNITY [United National Indian Tribal Youth] Inc., to host a luncheon for youth participating in the UNITY mid-year conference next week.
- NIHB continues to serve on various health committees and advisory boards.
- The 40<sup>th</sup> anniversary of NIHB will be marked by an annual conference in Denver, Colorado the last week in September.

Ms. Reft invited Mr. Butler to present the updates for the Alaska Area:

- Two of the Tribal recipients of the National Public Health Improvement Initiative are in Alaska.
- Have a project looking at grants management.
- Moving forward with community health assessments.
- Production of *Traditional Foods, Contemporary Chef* continues, with episodes available on the internet.
- The *I Want the Kit* project, a computer based self-testing opportunity for STIs, has about a 25% return rate.
- Thanked CDC for support of the Universal Vaccine Program in Alaska, which has now gone away. Expressed appreciation for the Art of Investigations Program.
- Acknowledged the *Did You Know?* and *Have You Heard?* initiatives.
- Hosted the NIHB Consumer Conference, which yielded a follow-up activity related to looking at data from the Adverse Childhood Events Study to see how it might apply in Indian Country. Leadership has been looking at data and seeing how it might affect Indian Country. Suggested that Dr. Rob Anda (sp), one of the co-principal investigators of the original study to address the TAC.
- Acknowledged CDC grants for colon/rectal cancer screening.
- Last week there was a briefing for state health officers pertaining to the Strategic National Stockpile and there is a concern if the distribution model will reduce the assets available to the most remote parts of Indian Country.

Vice President Jim shared updates from the Navajo Nation. Among the highlights from his presentation included the following items:

- Navajo Nation disseminates information on CDC to the Navajo Nation Council, as well as various committees, divisions, programs, organizations and through the Navajo Nation State Address. Also started a newsletter and distributes information through conferences.
- Public health issues include: need for Tribes to have the option to receive direct funding from CDC; need for Tribes to have direct access to Tribal health data (federal, state, and local sources); Epidemiology centers need to establish technological data infrastructures to store, retrieve, and analyze data regarding the local health status of AI/ANs; need for AI/AN surveillance systems; need more effective collaboration across Tribal federal agencies and states; and need for more effective Tribal consultations.
- Funded with a cooperative agreement with the National Public Health Improvement Initiative for Performance Improvement to prepare for the public health accreditation board.
- Developing a Navajo Cancer Control Plan to address cancer concerns.
- Advocating for research on uranium expose.
- Seeks additional funds to address health disparities.
- Vaccinations needed for high risk groups.
- Need funding to build staffing capacities.
- Breast and Cervical Cancer Prevention Program is taking a mammography unit to remote areas. Started a partnership with a professional golfer to raise awareness on physical activity and build more soccer fields.
- Addressing oral health through mobile units and hoping some dentists will do volunteer work on Navajo.
- Collaborates with spiritual leaders on public health outreach and asking them to serve healthier foods at ceremonies.
- CDC should be aware of: Navajo's desire for direct funding whenever possible; CDC public health preparedness is not distributed adequately to benefit the entire Navajo Nation; want to meet on stockpiles; and needs funding and technical assistance for the Medicaid Feasibility Study.
- Navajo Nation wants to build effective policies to build its workforce capacity; health data management infrastructure, and surveillance systems.
- Requests technical support in the form of a special assignment of a public health advisor to assist with addressing environmental and infectious disease concerns on the Navajo Nation.

### Discussion Points

Dr. Holzman asked specifically what the Navajo Nation was requesting in terms of the technical assistance for the Medicaid Feasibility Study. A member of Vice President Jim's staff responded that technical assistance was being requested for the design of the feasibility study and in developing a timeline to implement the study. She also said the Navajo wanted to be involved in determining where the study will be conducted. Dr. Holzman asked if the study was intended to see if the Navajo could have its own Medicaid system. He was told, "Yes, it's to take on all CMS services. The federal government doesn't understand that we don't recognize state lines. We have families that are mobile and it's important to have accessibility to Medicaid and Medicare in all three states."

Chairman Antone indicated that the remainder of the updates would occur later in the day.

## **Health Care Reform – CDC Perspective**

### **Lydia Ogden, PhD, MPP, MA: Director, Health Reform Strategy, Policy, and Coordination Office (HRSPC), Office of the Associate Director for Policy, Centers for Disease Control and Prevention**

Dr. Ogden indicated that the Office for Health Reform Strategy, Policy, and Coordination (HRSPC) was created in August 2011, stating that she is its Director. She said the Office deals with anything that has to do with the ACA or health reform, more largely. She also noted that her complementary office is the Office of Prevention through Health Care, which is responsible for working to integrate prevention into the health care system. She said the U.S. is experiencing rising health care costs, demographic changes, and mounting fiscal woes. With that in mind, her presentation focused on addressing:

1. What is the problem we are trying to fix;
2. An overview of the ACA and how it addresses that problem(s);
3. Opportunities for public health vis-à-vis the ACA.

Dr. Ogden showed the per capita U.S. health expenditures in 2009, noting that on average \$7960 was spent per person as compared to \$3032 per person in other industrialized countries. With the U.S. spending more than twice as much as others, she questioned the value of what is being spent when the U.S. is not doing well as those other systems in many areas, e.g., low birth weight, hypertension under control, diabetes under control. In 2011, she said, \$2.7 trillion was spent on health in the U.S. (with 3% spent on government public health activities and the bulk of the resources going towards restorative health). In terms of who pays, she said private and public expenditures were about neck and neck, which has state and federal governments particularly worried because it will be difficult to sustain the rising expenses. In the federal government, Medicare and Medicaid combined make up 21% of the overall spending, social security 19%, and defense spending 20%. So, as health care spending rises, the net interest on the U.S. debt rises, and social security rises because of the baby boomers, all other programs have to shrink. Additionally, she said Medicaid is being called the “Pac Man” of state expenditures because of its rapid growth over the last decade (accounting for about 21% of state expenditures). In terms of the current situation, she said we are on an unsustainable path. With that in mind, the ACA was designed to deliver better health, better care, and lower costs. “If we expand insurance coverage to near universal coverage in the US (95%) and expand access to care, and emphasize primary care, and increase the supply of primary care providers and other allied health professionals, we will enable people to get better care, high value care, and will reduce health spending over time.”

Dr. Ogden listed various Titles in the law, noting that Title VIII (the Class Act) was scheduled to be repealed the following day by the House; and stating that Title X (Part 3) includes the Indian Health Care Improvement provisions. Next, she discussed 5 key themes in the ACA: expansion of coverage; new consumer protections and choice; making health care more affordable; improving quality (creating New Center for Medicare and Medicaid Innovation); and improving prevention in public health. She said a key question for public health is, “What will it mean for public health when 95% of Americans have health insurance starting 2016?” In many cases, she said, public health has been acting as the safety net provider. The question is will that still need to be the case? She said a lot of state health departments have moved out of the direct clinical service provision

business, while others are continuing to provide clinical services. She said opportunities for public health include expanded insurance coverage and access; policy and regulations looking at structural interventions to promote healthy choices; essential health benefits packages; immunizations; screenings; smoking cessation; ongoing interventions; medication adherence; and personalized behavioral interventions. She shared example provisions in the ACA; and she talked about parts of the Act intended to increase individual health and well being, e.g., preventive care with no cost sharing; and preventive guidelines for children, adolescents, and women. Dr. Ogden also mentioned that the CDC is funding technical assistance and capacity building for workplace wellness provisions, to ensure they are evidence based. For communities and states, the Community Transformation Grants build on the Communities Putting Prevention to Work initiatives (and of that money \$6 million went to Tribes). In closing, Dr. Ogden said the ACA permanently reauthorizes the Indian Health Care Improvement Act (IHCIA), authorizes new programs and services with IHS, and provides AI/ANs with more choices; she discussed the National Prevention Strategy; and outlined the four functions her office is responsible for regarding the ACA, i.e., monitoring the implementation of the ACA, interpreting the legislation and figuring out implications for public health, helping programs achieve the best leverage they can to increase public health effectiveness, and serve as a point of contact for the department for other operating divisions within HHS for the White House and for others.

#### Discussion Points

Q: (J.T. Petherick) Do you provide support to states?

Q: (Lydia Ogden) Are you talking about technical assistance or fiscal support?

A: (J.T. Petherick) Technical assistance, like help with Exchanges.

A: (Lydia Ogden) I've had a few requests. Historically CDC hasn't been seen as a player in the health insurance game. I'm letting people know we are around to help in any way we can.

Q: (J.T. Petherick) In Oklahoma they are trying to figure out how to utilize technical assistance, so access to the right information about how they should approach reform would be useful.

A: (Lydia Ogden) In terms of building prevention into essential health benefits packages, we could help.

Q: (Connie Hilbert) Is it possible for you to get this presentation to Kim [Cantrell] so she can send it out to us?

A: (Lydia Ogden) We'll work on that for you.

Q: (Connie Hilbert) Regarding workplace wellness, are you available to provide technical assistance to those looking to establish workplace wellness programs?

A: (Lydia Ogden) Yes. CDC has a specific workplace wellness program. That is not out of my office. Folks in OSTLTS or my office can connect you to the right people. The program is housed in the Chronic Disease Center. We can get you the contact.

Q: (Chester Antone) Does CDC have a role to play in IHCIA?

A: (Lydia Ogden) I think so, I'll point to Delight.

A: (Delight Satter) We can help in any capacity we can. IHCIA was made permanent as part of the ACA. Within IHS, this means many services are not authorized, e.g., long-term care. There are three main points to keep in mind:

- 1) Natives will have more frequent enrollment periods (under Health Benefit Exchanges);
- 2) There will be no cost sharing if the program is implemented as intended for Natives who are under the 300% federal poverty level; and there will be no penalty for failure to carry the minimum coverage.

CDC is a great place to come to for technical assistance in some of these areas, e.g., clinical preventative services and long-term care services. I would say that individuals should expect more service through IHS, Tribes, and urban Indian programs, as well as the rest of the health system. There will be more opportunities for coverage for Indian people; and there will be more options for care. There is a need for education of new providers on new populations; and there will be more collaboration with non-Tribal partners, as the system will encourage new partners for individuals and systems.

Q: (Chester Antone) Does CDC have a role in the evaluation of how these intended programs are affecting health care delivery?

A: (Lydia Ogden) CDC is part of the Monitoring and Evaluation Group (MEG) to look comprehensively at how to evaluate the effects on individual health, population health, the delivery of care, outcomes of care, and other areas. In the next couple of months CDC will release a special supplement to the MMWR [Morbidity and Mortality Weekly Report] that looks at surveillance at core clinical services and health outcome metrics to get a baseline measure before the implementation of health reform. We will be tracking those things over time to shed light on how people are doing.

Q: (Chester Antone) Do you have a role in determining the effectiveness or non-effectiveness of treatments?

A: (Lydia Ogden) The various CDC programs that have a clinical component have had clinical components for a long time. They have always tried to work closely with providers and with payers like CMS to evaluate outcomes of care. I would expect that to continue and expand.

Q: (Chester Antone) So would you then be recommending or would you be doing a study to determine if a treatment is effective or not?

A: (Lydia Ogden) Typically very specific effectiveness questions are addressed by the Agency for Healthcare Research and Quality (AHRQ). We do work with them closely.

Q: (Chester Antone) So earlier when you talked about monitoring and evaluation, is there a particular component of the IHCIA that CDC is involved with?

A: (Lydia Ogden) I will have to go back to the MEG and ask that.

Q: (Chester Antone) On the insurance exchange, how would that look for Arizona? You know they are refusing to do the exchange, so the federal government would have to provide it.

A: (Lydia Ogden) To some degree these things change day-to-day. Many governors and state legislatures, even if they are opposed to health care reform, know they can't wait to set up an exchange because they don't want the federal exchange if the law is upheld by the Supreme Court this summer. So, many of them are preparing for a state-based exchange. I can get back to you on information on Arizona.

Q: (J.T. Petherick) Can you provide an update on the Prevention Fund? It is funding Community Transformation Grants, right? As I understand it there were some applications that were approved but not funded. Will they be funded?

A: (Lydia Ogden) I don't have the current numbers for the fund, but I can get back to you on that. The program continues to evolve, but the future is uncertain under the current fiscal constraints.

Q: (Chester Antone) What is CDC's involvement in the HHS Action Plan to Reduce Racial and Ethnic Health Disparities and its role in the National Plan of Action?

A: (Lydia Ogden) We should defer that question until tomorrow for the Chronic Disease Center. That program, as well as the Community Transformation grants and the Workplace Wellness grants are all housed in the Chronic Disease Center.

Q: (Chester Antone) Would they all work together to eliminate health disparities?

A: (Lydia Ogden) Yes.

Q: (Chester Antone) Does the center you mentioned have specific authority according to the Secretary's plan to become engaged in [unintelligible]?

A: (Lydia Ogden) I don't know the answer to that question. That would be a question for them. The REACH program is housed in that center. I'm assuming under that plan that REACH has the authority to continue the work that it has been doing. That is a question for the Chronic Disease Center.

Q: (Chester Antone) In evaluating and monitoring specific treatment questions, that is under AHRQ?

A: (Lydia Ogden) Yes.

Q: (Chester Antone) And then the National Plan of Action and the HHS Strategic Plan and health reform are kind of all over, but specifically being dealt with in two centers of CDC?

A: (Lydia Ogden) Mostly in the Chronic Disease Center, but not exclusively. The infrastructure pieces, like surveillance and informatics, are housed in the Office of Surveillance and Epidemiology Labs (OSEL).

### **CDC/ATSDR Budget**

**Carol J. McElroy, Acting Deputy Director/Budget Officer, Financial Management Office, Centers for Disease Control and Prevention**

**Michael Franklin, Financial Management Office, Centers for Disease Control and Prevention**  
**Delight Satter, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Center for Disease Control and Prevention**

Ms. McElroy began the CDC/ATSDR presentation by sharing FY 2011 resource allocations for programs that benefit AI/AN populations, noting that reports on awarded contracts were pulled to collect the information. She also clarified that all of the information was pulled from financial data systems. Overall funding to AI/AN programs (as of September 30, 2011) was slightly over \$226 million, of which the majority (69%) was Vaccines for Children (VFC) funding. This reflected a 16 percent total increase over FY 2010 funds, with the largest percentage of growth occurring in

contract funding. Ms. McElroy provided comparison data on funding as distributed among AI/AN populations for FY2010 and FY 2011, as well as by specific disease areas.

### Discussion Points

Q: (J.T. Petherick) On the vaccine numbers, how was data on AI/ANs calculated? I'm guessing those grants go to the state?

A: (Carol McElroy) Yes, the grants go to the states. It is formula based. The VFC program is a \$4 billion program. The estimated VFC population is almost 41 million, with the AI/AN population being 1.6 million of that (3.95%). That is how the funding was derived.

C: (J.T. Petherick) Maybe as an advisory group we need to see if those funds are actually reaching the population it is intended for.

C: (Carol McElroy) There are two parts, this is just the grants. What is not included in that is the vaccine which the providers purchase through the CDC purchasing system. Each provider in the states order vaccines which are then provided to patients. Those numbers are actually not captured here. Those are considered supplies as opposed to contracts.

Q: (Chester Antone) What areas are you looking at in terms of the 2% cut being discussed as part of sequestration?

A: (Michael Franklin) I would defer to program officers who provide grants to your communities. When you look at the slides, you can see changes in disease lines. I would focus on those offices.

Q: (Greg Holzman) When you talk about the 2%, are you talking about the agreement that happened with IHS, that no more than 2% cuts would happen?

A: (Chester Antone) No, I'm talking about the sequestration. Since the Super-committee failed, my understanding is that there would be a 2% cut overall. Do you have any idea where you would make cuts?

A: (Michael Franklin) That would depend on Congress. For CDC, grants and cooperative agreements should not be effected. A 0.189% cut is what CDC took. Our direction has been that we try to maintain grants at 2011 levels. It doesn't mean money has to go to the same grantees. We are directed to take cuts in our intramural programs (administrative expenses, travel, space) and not pass them on to our external customers.

Q: (Stacy Bohlen) Is there a way to determine which line items are competitive versus sole-sourced?

A: (Carol McElroy) I think we should be able to get that information from the Grants and Procurement Office.

C: (Michael Franklin) Yes, we can find out. Overall, grants and co-op agreements are competitive; but I would need to see if anything was sole-sourced.

C: (Stacy Bohlen) Because of treaties NIHB upholds the rights of Tribes, so we want to see where Tribes have to compete for dollars.

Ms. Satter thanked the team that assisted with the CDC/ASTDR budget presentations, stating that more information would be provided at the next meeting.

### **Special Presentation**

Dr. Melanie Duckworth was honored with a special “thank you” presentation for her work. Ms. Satter shared slides about Dr. Duckworth and Chairman Antone presented her with a gift on behalf of the Tribes and the CDC.

### **CDC Tribal Support Office Update**

**Delight Satter, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention.**

Ms. Satter provided an update on the OSTLTS. Specifically, she shared responsibilities of the Office and noted its current activities. Items of particular interest included:

- Tribal Consultation Report (provided in binder).
- Improved communication with the TAC and CDC.
- Completed report to Congress on the Social and Economic Conditions of Native Americans.
- Completed OMHHE [Office of Minority Health and Health Equity] Tribal Colleges and Universities Investment reports.
- Pending FOA [Funding Opportunity Announcement] release (on infrastructure and winnable battles).

As part of her remarks, Ms. Satter also discussed cross-CDC activities such as the PHLP/OSTLTS, Tribal Judiciary Public Health pilot; ATSDR National Tribal Environmental Think Tank; and a Tribal and State Collaborative Roundtable scheduled for the coming Friday.

### **Public Health Law Program**

**Matthew Penn, JD, MLIS, Director, Public Health Law Program, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention**

Mr. Penn shared his background prior to CDC and then proceeded to provide information on the Public Health Law Program. He indicated that the program has ten attorneys working in three areas:

- Serving as a resource within CDC for programs that touch on state, Tribal, and territorial laws to make sure the laws are appropriately integrated into program initiatives.
- Providing legally-based technical assistance, working with state, local, and Tribal health departments as they grapple with issues.
- Providing public health law training and developing curriculum to give the national public health community an understanding of public health law.

Mr. Penn said the second area was probably most relevant to the group, giving an example of a project in Alaska where they helped a consortium of hospitals that was wrestling with trying to make their employee health immunization policies consistent across the hospitals. He also cited examples of work such as providing legal work to the Cherokee Nation and Navajo Nation; and work with the University of Pittsburg on public health training for the judiciary and how it can be adapted for

Tribal Nations. Mr. Penn also noted a recent request for technical assistance from the Umatilla Tribe in the northwest as they attempt to go for accreditation, as one of the criteria for the accreditation is to conduct a legal review. Because the program did similar work with the city of New Orleans, it hopes that the information will be useful to the Umatilla Tribe. In closing, Mr. Penn's colleague Montrece Ransom, Public Health Analyst, PHLP, OSTLTS, CDC, said the Public Law Program was in the mist of launching a needs assessment for training and technical assistance in the field and wanted to make sure that Tribes were included. She encouraged them to subscribe to CDC Public Health Law News, stating that she had copies of the November 2011 issue that focused on Tribal law for review. Mr. Penn added that the upcoming February edition would include a Tribal interview with Michael Byrd.

### Discussion Points

Q: (Unknown) Did you say you provided technical assistance for policy related to injuries?

A: (Matthew Penn) We have projects in the office right now that we are doing in partnership with the Injury Center, yes.

Q: (Unknown) What about traffic safety laws? Do you help Tribes with technical assistance in developing those types of laws?

A: (Matthew Penn) We don't currently, but we certainly can. On motor vehicle laws right now, we have a contract for a computer system called CQ State Track (sp). It actually tracks legislation in the 50 states as it moves through the state legislature. We've been asking them to add jurisdictions, i.e., Tribes, and local and territorial health departments.

C: (Stacy Bohlen) NIHB will host a National Public Health Summit in Tulsa, Oklahoma at the end of May/beginning of June. It would be great to have a public health law mini seminar, so we invite you to do that.

C: (Matthew Penn) Great. Thank you.

C: (Chester Antone) I encourage everyone to go learn more about the Public Health Law Program because it could be useful to many Tribes.

C: (Matthew Penn) Our goal is to help you reach your goals and find solutions to your issues.

### **ATSDR Updates**

#### **Annabelle M. Allison, Tribal Liaison, Office of Tribal Affairs, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry**

Ms. Allison said the Office of Tribal Affairs (OTA), National Center for Environmental Health/Agency for Toxic Substances and Disease Registry (NCEH/ATSDR), underwent an exercise last year to consider the strategic direction the office should take in terms of environmental health in both the short and long-term. She said as they went through the exercise they found that there were many definitions of environmental health and many crossroads between environmental health and public health. The Think Tank Initiative was established to develop a 3 to 5 year plan in terms of the vision of the OTA. Twelve Tribal professionals were recruited to serve as members of the Think Tank and NIHB served as their contractor. The first three meetings focused on creating a strategic analysis and setting the foundation for the Think Tank, discussing major environmental concerns of

Tribes, and developing a strategic plan to address the issues, respectively. To guide its work, the Think Tank set seven guiding principles and established guiding pillars for its strategic plan. The group identified training, education, and mentorship as priority activities; and it noted the importance of doing more work with urban Indians, using Tribal Epidemiology Centers, including representation from the Pacific Island region and the Navajo Nation in its membership, getting leadership buy-in, and keeping its efforts going. Ms. Allison said the Think Tank is now in the process of drafting its strategic plan and hopes to it completed by the spring of this year. After acknowledging the work of Ms. Ransom and Chinyere Ekechi, Ms. Allison also noted that the Think Tank will look at public health topics, not just environmental health.

### Discussion Points

Q: (Delight Satter) Earlier today there was a question around environmental issues in Montana. Is there follow-up on those issues?

A: (Annabelle Allison) In July of 2010, some TAC members took a tour of a mine that is said to have environmental health impacts and not getting visibility in terms of remediation. There was a request that ATSDR look at the data. We've been going back and forth with the Tribe in terms of accessing data. We are waiting to get data from the Tribe now.

### **Area/Organizational Updates (con't)**

Ms. McKinley provided the update for the Phoenix Area:

- IHCA Section 214 says CDC shall give technical assistance to Tribal Epidemiology Centers. Wants assurance from CDC that Tribal data will be transmitted to the Epidemiology Centers and coordinated with IHS.
- Public health activities include: the Southwest Indian Collaborative Network is developing a 2-day web based Patient Navigator Certified Trainer Program.
- ITCA [Inter Tribal Council of Arizona] Dental Prevention and Clinical Support Center provides continuing education and training for dental program staff.
- ITCA Tribal Epidemiology Center is preparing community health profiles to evaluate community health status of Tribes.
- CDC should be aware of public health issues such as chronic pain management; patient education on prescription medication, diabetes care management, home health services for elders, women's health care service enhancements, and the need for adult male residential treatment services for alcohol and substance abuse.
- Fort Yuma Ambulatory Health Care facility has been declared unsafe and process is underway to relocate services.
- Recommended that TAC members through support from CDC's OSTLTS be present at HHS Regional Tribal Consultation sessions to obtain advisement from Tribal leaders on policy concerns, budgetary matters, and public health collaborations.

Ms. Hunter shared updates from the California Area. Among the highlights of her presentation included the following:

- CRIHB [California Rural Indian Health Board] disseminates information via list servs, presentations, newsletters, board meetings, conferences, and community health events, among other vehicles.
- Engaged in nationwide tobacco surveillance and monitoring project.
- Public health issues include a need for more funding for public health programs and services (tobacco, substance and alcohol abuse, HIV/AIDS, suicide, injuries, and elder falls). Other areas of concern are social determinants of health especially in babies and children, maternal and child health services, home visiting resources, services for youth, and public health accreditation (related to capacity of small Tribes to engage in work and achieve accreditation).
- Public health activities being planned include injury prevention activities for children, e.g., car seat installation, home safety, and bike and recreation safety.
- As a result of a Tribal Motor Vehicle Injury Prevention Program grant, Yurok Tribal police have been trained in the National Highway Traffic Safety Administration's Child Passenger Certification course. The grant also enabled the production of a media campaign on road safety.
- CRIHB is engaged in ongoing consultations and nutritional health assistance with Tribal Head Start programs.
- PHAP fellow was awarded in California.
- Tribal consultation is still a priority.

Chairman Antone provided the update for the Tucson Area. Highlights are as follows:

- Mode of communication is through the CDC list serv, and via radio stations.
- There is a Rocky Mountain Spotted Fever outbreak on Tohono Nation, with 11 confirmed cases. (Meeting scheduled on February 17<sup>th</sup> for all Arizona Tribes to discuss the issue.)
- A CDC H1N1 study is being conducted.
- Public health activities: *Tough Enough to Wear Pink* at the rodeo; half marathons; and other year-round activities.
- Held a Research Review Process meeting to work towards getting an IRB [Institutional Review Board] for Nations without one.
- Need additional research related to cancer, cardio vascular disease, and diabetes.
- Should begin to look at social determinants of health in conjunction with the National Plan of Action and the Secretary's Strategic Plan to Eliminate Health Disparities.
- Should scrutinize budgets to protect funds most used by AI/ANs.
- Would like insight into current financial information compiled by Ms. Satter's office using financial information retrieved from the Financial Office.

Joe Bray conveyed Tribal Self-Governance support of this meeting.

### **Gateway Presentation**

**Chelsea Payne, Lead Health Communications Specialist, OSTLTS, CDC**

Ms. Satter asked for and received permission from Chairman Antone to have a demonstration of the CDC Gateway. Ms. Payne led the demonstration, stating that the Gateway was intended to be a one-stop-shop to locate CDC information that individuals needed to better do their jobs. She noted that the homepage contained constantly changing information, as well as a “What’s New” section.

She provided an overview of the site, highlighting products on the homepage and the CDC online resource directory. She commented that the site is still under revision. Notably, she said the Tribal Support section was outdated; and she welcomed input to improve it.

### Discussion Points

Q: (Connie Hilbert) Can you reach staff via instant messaging?

A: (Annabelle Allison) Right now no, but I’ll look into it if you think that would be helpful. That’s the type of feedback we want.

C: (Chester Antone) More information on Native Americans will be helpful, i.e., Native-specific information. A listing of personnel will be good, so we can contact people when we need to. I would also recommend some type of warning system to say an email or phone call is a priority call.

Q: (Unknown) Will there be links to other pages?

A: (Annabelle Allison) Yes.

Following the question and answers, Ms. Hilbert and Mr. Butler volunteered to assist Ms. Allison by providing feedback on the site. Mr. Petherick also agreed to volunteer one of his staff to help.

### **Day 1 Wrap-up**

**Delight Satter, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention.**

Ms. Satter recapped the events of the day, confirming that the next TAC meeting would be held in Wisconsin; and a subcommittee had been established to work on the CDC Tribal Consultation Policy and TAC Charter. Ms. Satter also thanked the Tribal leaders for their updates and the presenters for their presentations.

### **Day 1 Closing Blessing**

Lester Secatero provided the closing blessing.

## **Day 2 Opening Blessing/Welcome**

**Brenda Nielson, Co-Chair, TAC**

**Delight Satter, Associate Director for Tribal Support, Tribal Support Office, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention**

The second day of the CDC/ATSDR TAC meeting started with TAC Co-Chair Brenda Nielson welcoming the group back and inviting her fellow Co-Chair Chester Antone to provide the opening blessing.

After offering welcoming remarks to the TAC, Ms. Satter provided a brief introduction of herself. She chronicled her life, from growing up in the State of Washington, to attending the University of Washington and the University of Minnesota, to helping nurses and dietitians talk to each other as one of her first jobs in the field. She also shared personal information about her family, commenting that her great-grandparents lived to be 106 and 110; and her Norwegian father was a sportsman who liked to hike and taught her how to build an igloo. A self-proclaimed “Urban Indian” after turning 20 years old, Ms. Satter said she was happy to be a federal employee again; and she thanked Dr. Monroe, Dr. Holman, and others for making her feel welcomed.

Dr. Holzman next shared information about himself and his work. He expressed his commitment to improving health for all, including Indians; and he noted his appreciation of a visit he had taken to the Makah Tribe in Washington.

Remarking that she too had a similar childhood as that one described by Ms. Satter, Chairwoman Nielson proceeded to ask for brief introductions from the TAC members. The Committee’s introductions were followed by introductions by members of the audience.

## **Work Together on Laboratory Issues**

**Carlyn Collins, MD, MPH: Expert Advisor to the Director, Laboratory Science, Policy, and Practice Program Office, Office of Surveillance, Epidemiology and Laboratory Services, Centers for Disease Control and Prevention**

A staff member in Laboratory Science, Policy, and Practice Program (LSPPP) Office, Dr. Collins stated that laboratories are a central part of health care efforts. Laboratory testing is done in a variety of settings, from hospitals to small clinics. Dr. Collins said some entities even contract with larger labs and/or use state public health laboratories. Despite estimates that say 70% of decisions in health care are made based on a lab tests, Dr. Collins said laboratories sometimes get overlooked. In earlier days, she said there was a Bureau of Laboratories at CDC and they all worked together. Now, CDC labs sit with their programs and are therefore fragmented.

Dr. Collins showed an organizational chart and shared the directive of the LSPPP, part of which is to connect CDC with various stakeholders (including Tribes) on cross-cutting laboratories issues. Among LSPPP’s activities include improving accuracy and reliability of laboratory testing; active engagement with the APHL [Association of Public Health Laboratories] and state and local health departments; informatics; quality practices; and workforce development. Noting that the National

Laboratory Network does trainings around the country, Dr. Collins next discussed what may be useful to laboratories that serve Native health systems, e.g., training in lab science and practice; assistance for preparedness and emergency response; communication networks; linkages to APHL, state and local public health labs; linkages to CDC programs; and technical assistance. Dr. Collins said LSPPP could also assist with increasing CDC's knowledge of unique Tribal health issues and helping to develop solutions to address them. Notably, she said employment of an electronic system could be used to get messages to laboratories. Stating that the more they know about what labs need the more opportunities they have to help, and acknowledging that they didn't have a clear picture of what Tribal laboratory services are performed, Dr. Collins asked:

- Are the services I described something that would be useful to Tribes?
- What are the best ways to go about the effort?
- Whom should we speak to?

### Discussion Points

C: (Chester Antone) Most of our lab work in Indian Country is tied to IHS. Most of the communications would be with IHS. I don't know what the Urban Indians do. Recently we had an STD outbreak. Samples were taken and transferred to the state and then to CDC. The blood draws were taken at clinics and hospitals.

C: (J.T. Petherick) Lab issues that arise from clinical settings would go like Chester described. Are you talking more about outbreaks? We don't have any capacity around that. We would have to go to state and/or local partners. Maybe we can work out agreements with them to formalize relationships.

C: (Carlyn Collins) We do have relationships with state labs, so we may be useful. A lot of labs contract out their work. We could help think through what is the best contractual arrangement. I imagine you have some place where simple testing is done. If you think you need this, I'm hoping to share information on training opportunities and improve quality practices. Our lab testing is federally regulated; it's called CLIO (sp). We publish guidelines on how to do tests. I want to make sure Tribes are aware of the resources that are available.

C: (Rex Lee Jim) I'm not sure how our lab system is set up. If you give me a copy of the questions, I can send written answers. There is a need for technical support I'm sure. Often we don't get technical support, so we need a clear communications system in place so when we ask for technical assistance we get a response in a timely manner.

C: (Joe Finkbonner) I know it would be useful if you used communication tools such as "Do You Know?" and "Have You Heard?" We could send stuff out; or if you had trainings archived online or available on CD that would be great.

C: (Carlyn Collins) CDC is developing the Learning Connection, a website where all CDC web-based training can be accessed. We are in the process of getting our trainings on that site now.

C: (Unknown - Rex Lee Jim's staff) On Navajo Nation we could use technical assistance to build infrastructure. We rely on IHS and 638 facilities and the states we are surrounded by. The best ways to proceed, the best place to put the labs are under the Navajo Epidemiology Centers. We can do our own studies and do forensics. CDC should speak with the Vice President and President of the Navajo Nation.

C: (Connie Hilbert) We don't have a clinic on our reservation, but we have a union operation and business entity for which we have a sampling program. We serve a lot of ice and frozen desserts, so we have things we have tested. We worked with the Connecticut Department of Public Health Lab. We were the only health department in the state that sampled ice. About 6 years ago they said they couldn't serve us anymore. We have been forced to look at private laboratories. We established a relationship with a local lab that works for half the price, so now we can do more sampling and surveillance regarding public health issues. It was disappointing that we couldn't work with the state partner.

C: (Carlyn Collins) Environmental testing is an important part of lab testing. I don't know about the problem in terms of the public health lab in Connecticut, but I know a lot of them are struggling. This is the type of thing we'd like to help you negotiate, and if it can't work to help you understand why.

C: (Lester Secatero) I don't know much about the lab. Most of us start with IHS. We sometimes work with the University of Mexico and we rely on the work of an Epidemiology Center in Albuquerque.

C: (Chester Antone) A lot of Tribes do sexual assault activities, so we may need training on this.

C: (Greg Holzman) I was thinking about the Association of American Indian Physicians. Maybe there is no similar organization for laboratorians. PHNet (sp) could do something with those working in labs in Native communities. They could archive things and get information out on trainings.

C: (Brenda Nielson) If you leave your contact information, we can take this back to our service units.

### **Rocky Mountain Spotted Fever in Arizona**

#### **Mark Miller, National Center for Environmental Health**

Mr. Miller discussed Rocky Mountain Spotted Fever, a bacteria that is transmitted by a tick (dog or wood) bite. Mr. Miller said the disease can be severe and difficult to diagnose. He also indicated that the rash often shows late and therefore it is important to get an early diagnosis and apply medication. Deaths do occur, as well as organ failure; and a high number of cases have been reported in eastern parts of the U.S. Additionally, he said there is a band of counties in Arizona that are Tribal areas with high rates. Specifically in Arizona, the brown dog tick is emerging. Mr. Miller explained that ticks can lay hundreds of eggs, quickly resulting in an explosion of the population; and in some areas there is a high tick load, which increases the chance of disease. Mr. Miller cited

increases over the years, with 194 cases in Arizona from 2003 – 2011 (disproportionately affecting Native American populations and impacting children). Mr. Miller emphasized the need for animal control and veterinary care, as evidenced by a survey this summer that cited that 70% of dogs on two reservations in Arizona were free-roaming. Dogs, especially puppies, get sick from this disease; and new puppies can transfer the disease to other ticks. Prevention efforts include treating the dog for ticks (collars, dips, sprays); treating the environment (with sprays); controlling the dog population through spaying/neutering; changing the free-roaming culture; reduce harborage; and educating people.

Mr. Miller discussed an upcoming effort, the Neighborhood Pilot Project, where one community will allow removal of unwanted dogs, be provided collars, have dogs and homes treated on a regular basis, receive education for homeowners, and get monitored for changes in Rocky Mountain Spotted Fever. The goal of the project, Mr. Miller said, is to improve human health by improving the health of the pet population. In closing, he listed partners in the effort and gave his contact information.

### Discussion Points

Q: (Unknown) Will there be a communication/education campaign connected with this effort?

A: (Mark Miller) Yes, we will go into the community and talk about the program. The campaign will start in March to advertise the pilot project.

Q: (Rex Lee Jim) Does eastern Arizona include Navajo?

A: (Mark Miller) I'm trying to track down some testing that was done for dog serology on the Navajo. I've not been able to get it. Apparently it was an older study. Last summer there was a study done on Hopi and 60% of the dogs had been bitten by a tick that had RMSF. On February 17<sup>th</sup> there will be a statewide meeting on RMSF in Chandler, Arizona.

Q: (Rex Lee Jim) Will there be conference call capabilities for that meeting?

A: (Mark Miller) I think so.

Q: (Lester Secatero) In my community we picked up 176 unwanted dogs. Now we have regulations that say you need collars on dogs. What is the treatment for Rocky Mountain Spotted Fever?

A: (Mark Miller) An antibiotic, Doxycycline. If administered early, it will have an immediate impact. If administered late, the person can suffer ill health effects or death.

C: (Lester Secatero) At times the Navajo Nation spays and neuters dogs for free. It's very expensive.

C: (Mark Miller) We need a lot of partners to make a difference. It's a combination of animal control and providing the spay/neuter services.

C: (Stacy Bohlen) One idea is to partner with the Humane Society.

C: (Mark Miller) I agree, the Humane Society is a great partner and heavily involved with animal control services.

Q: (Stacy Bohlen) What about the development of a vaccine? Is there any progress or promise for humans and/or dogs?

A: (Mark Miller) Not that I'm aware of. What I've read is that the feasibility of doing that is problematic. We do know through active controls we can make a difference. If we can control the tick population then we can have an impact. It may take several years.

Q: (Stacy Bohlen) Regarding the pilot program, are there programs in mainstream America that worked?

A: (Mark Miller) In some areas there are effective animal control programs, so we haven't seen a spread. We have an integrated pest management training coming up February 13-15, 2012. We will have a full day on animal control.

Q: (Delight Satter) Can someone speak to traditional concerns and euthanasia?

A: (Brenda Nielson) My elders said four consecutive days of swimming in the Pacific ocean would cure dogs of fleas and ticks.

### **Public Health Associate Program**

#### **Rachael Johnson, Public Health Associate Program**

The Public Health Associate Program (PHAP) takes recent bachelors graduates and places them for 2 years at public health agencies. First piloted in 2007, in 2010 the PHAP became a nationwide program. Ms. Johnson informed the TAC that the program currently has 119 associates that cover 26 states, 3 Tribes, 1 territory, and the District of Columbia. Sample program areas in which associates work include STD/TB and/or HIV; chronic disease; environmental health; and public health preparedness. Ms. Johnson noted the three associates placed with Tribes: Allysa Llamas in Billings, Montana; Lan Lee in Sacramento, California; and Caroline Sedano in Tokeland, Washington. Ms. Johnson identified two gaps in the program. First, she said, there is no strong representation of Indian Tribes as host sites. Secondly, there is only 1% Native American participation as associates. To encourage Tribes' participation, Ms. Johnson explained some of the benefits of being a host site and shared eligibility criteria. She also discussed core competencies needed by associates and provided an overview of the process from recruitment through placement. In closing, Ms. Johnson said the applications for associates and host sites open that day and would remain open for 6 weeks.

#### Discussion Points

Q: (Brenda Nielson) You said the application process opens today. Where do we find information to apply?

A: (Rachael Johnson) You can visit <http://www.cdc.gov/phap/>.

C: (Brenda Nielson) Carolyn in Washington state is a big part of the community and it's great to see the relationship working.

Q: (Connie Hilbert) How is achievement measured in the core competencies?

A: (Rachael Johnson) They are fairly new and right now there is a lot of self evaluation by associates reporting on their activities. We are trying to determine how else to evaluate the core competencies.

C: (Kristen Buswelez) We looked at other fellowships and existing CDC entry-level jobs to align the competencies we have.

Q: (Rex Lee Jim) How many host sites are in Native communities and what would it take to do the work?

A: (Rachael Johnson) There are two in Tribal Epidemiology Centers, one in California and one in Montana; and there is an associate in Washington.

C: (Kristen Buswelez) There is an application process for host sites that also opens today. We encourage you to apply.

Q: (Rex Lee Jim) What kind of work is being done in those areas?

A: (Rachael Johnson) Allysa Llamas does works with Indians Tribes in developing surveys and determining what goes into surveys related to environmental health. One of the other associates works in emergency preparedness and the other in STD/HIV.

Q: (Rex Lee Jim) What is the commitment of the host site in terms of finances?

A: (Rachael Johnson) The salary is paid by CDC, as well as travel to Atlanta for training. For training at the host site, the host site is expected to cover costs. You also have to have time, because these are students right out of college. You also need to offer computers, office space, and supplies.

C: (Kristen Buswelez) Supervising someone who is brand new requires a lot of mentorship, time and commitment.

Q: (Brenda Nielson) Part of the application process is to identify where we could use one of the associates, right? You would match the associate to the host site?

A: (Rachael Johnson) Yes.

C: (Lester Secatero) We had a couple trained in our Epi departments. I'd like to see a push to get Natives in the program. They are really ahead of the game when they come on the reservation, so I just wanted to tell you that.

C: (Kristen Buswelez) I have a personal commitment to the associates and I would too like to see a targeted effort to put Natives back in the community.

Q: (Connie Hilbert) What is the housing arrangements for the associates?

A: (Rachael Johnson) Many associates pay for housing and look for housing in the area, with the help of host site.

C: (Jane Kelly) A unifying theme I hear this morning is how to bring early experiences to work later in life. We need surveillance to know that what we do makes a difference.

C: (Kristen Buswelez) In terms of the host site application, I would encourage you to work with CDC funded programs to get help with the application.

C: (Judy Monroe) If a program like diabetes has an interest in having an associate in Indian Country, they could also sponsor additional associates.

C: (Greg Holzman) I'm a mentor to an associate and they are very bright. They can be an energy boost. I would ask if you know someone coming out of college, please send them to the website or give us a call because we want to increase the number of Tribal students that participate. For host sites, once they get accepted, it is CDC's choice where the person gets placed.

### **Introduction and Overview of Preparedness & Response Activities at NCEH/ATSDR and Collaboration with Tribal Communities**

#### **Rear Admiral Scott Deitchman, MD, MHP, Associate Director for Terrorism Preparedness and Emergency Response National Center for Environmental Health (NCEH) and Agency for Toxic Substances and Disease Registry (ATSDR)**

Dr. Deitchman explained that his office addresses environmental health emergencies, e.g., chemical, radiological, and natural disasters. Specifically, he said the office has two responsibilities: to develop guidance and recommendations for health departments to prepare for events and coordinate response to actual events; and to provide epidemiologic support to providing health interpretation data to providing public guidance. With regard to Tribal issues, he said he has been in a growth phase. Initially thinking that Tribes were connected to state health departments in times of disaster, Dr. Deitchman said he now realizes that is not always the case. He welcomed suggestions on how to make communications more efficient. "Disaster risk reduction says disaster is caused by a hazard or vulnerability to the hazard. If you can reduce vulnerability, then you wouldn't have the disaster." Dr. Deitchman indicated that disaster risk reduction is the next "big thing," and he looked forward to exploring it in terms of Tribal communities in future meetings. To that end, he said he would be happy to attend the TAC's next meeting in Wisconsin.

#### Discussion Points

Q: (Connie Hilbert) Can you speak to how your program differs from IHS in terms of assistance you would provide? Do you provide assistance if an emergency operations plans? If there were a major incident, would you provide assistance if an Emergency Operation Center had to be activated?

A: (Scott Deitchman) We haven't done those things yet, but they are certainly possibilities. This is part of my education. When we have a national disaster, there will typically be several conference calls—one led by FEMA for the entire federal response community. One is led by staff at HHS, to address the health related issues. On those health calls we hear reports from IHS. In my naivety I assumed they had it covered. Annabelle has been teaching me that we have to push further than that. We are still learning what the best points of intersection are where we can better understand what is being experienced by effected Tribal communities in a particular disaster. Working with the Division of State and Local Readiness, the CDC does provide assistance to support the development of emergency response plans. When an Emergency Operations Center has been established, typically FEMA or HHS will establish a federal center and we have sometimes been asked to send staff to be the public health representatives in that operation. It is less common for us to get a request directly from a state to have someone join them, but it has occasionally happened and we try to respond. If we get a request from a Tribal Nation to do that, I think we would want to respond the same way we would to a state. But I also think it's worth doing some advanced planning to better understand exactly what and EOC looks like in a Tribal community. At this point I've learned not to

assume. Are there special sensitivities or special organizational issues that we need to know ahead of time?

Q: (Connie Hilbert) I just wondered how your program differed from IHS in terms of the support you might provide a Tribe. In Connecticut we have a good relationship with the Connecticut Department of Public Health. We even have a letter of agreement that says we will cooperate if there was an incident. We've had to educate them on the sovereignty of our Tribe and the fact that this needs to be a government-to-government relationship. Do you provide any technical assistance with regard to writing emergency operations plans if and EOC had to be activated on the reservation? Would you look to the state first, if we requested you to come in? Depending on the incident, the state would already be allowed to be in our EOC because of the letter of agreement that we have. Where would you fit in all of this?

C: (Greg Smith) The states are funded through our program, and they have to fund Tribes and local health departments in their state through MOUs, direct funding, or in-kind [services]. I have to determine if Tribes concur with the application. Again, we fund the states directly. As a Tribal liaison, I must ensure we bring in other federal agencies in conjunction with our program if there is a need for technical assistance. We have to assure training is available to Tribes as needed. I can only negotiate with the state and the Tribes based on our guidance as funded from Congress. Congress would have to change the criteria in order for funding to go directly to Tribes. So, you can request technical assistance from my program. We do interact with all other federal funds that do deal with public health preparedness. I can negotiate with the Tribes, but I have to bring the state into the conversation as the funder of the Tribe's program. We want to ensure the Tribes receive the technical assistance they need. One issue I saw on a recent visit to a reservation was the need for HVA [hazard vulnerabilities assessment]. I'm also looking for a HRAs [health risk assessments], and I saw none of those. Tribes will need technical assistance through the state or directly in order to ensure that the scenario is completed. I am in a position to identify Tribes' need for technical assistance and ensure that it is available. If you need more information, I can be contacted directed.

Q: (Chester Antone) CDC developed guidance to all their grantees that they would have to get Tribal approval. Have states that used numbers from Tribes gotten Tribes to agree to what they are doing?

A: (Judy Monroe) Our office is working very closely with the PGO [Procurement and Grants Office] and the Associate Director of Programs here at CDC to standardize our FOA language. I will take that point back to the group that is addressing this, because we don't want to lose that point.

C: (Chester Antone) If you look back on previous consultations, the issue has come up. I was just letting CDC know that the guidance has been developed.

Q: (Greg Smith) What are we talking about?

A: (Chester Antone) In previous years the CDC attempted to do a guidance document in response to Tribes' concern about not being included in states' emergency plans and grants. The CDC developed a guidance document to address this. Particularly in emergency management, Tribes need to concur because states use Tribal numbers in order to get the grants. Sometimes Tribes get minimal services. Tribes need to concur that their numbers are correct. I was letting CDC know that that guidance was developed previously and was in use. Has that changed?

C: (Greg Smith) That has not changed. Each state should have a MOU/MOA in place with each Tribe. Each Tribe should concur or not-concur based on how the application will affect the Tribe.

We have 15 capabilities/guidances and we are focusing on community preparedness at this time. Our expectation is that when applications are sent into CDC, there should be concurrence or non-concurrence from each of the federally recognized Tribes. We should review the MOUs/MOAs to ensure that those Tribes receive their focus in regards to that capability.

### **Unregulated Water Sources in Tribal Communities: Background and Feedback for Potential Funding Opportunity**

#### **Matthew Murphy, PhD, MS, CDC National Center for Environmental Health (NCEH)/Health Studies Branch**

Dr. Murphy began his presentation by sharing background information on the Health Studies Branch of the National Center for Environmental Health. He stated that the Health Studies Branch conducts environmental health research, conducts outbreak investigations, prepares for and responds to disasters, provides technical assistance and expertise to public health partners, and runs the Clean Water for Health Program. He said the latter focuses on identifying and evaluating non-infections contamination of unregulated drinking water sources, e.g., private wells, natural springs, rainwater, and surface water, as well as evaluating potential contamination risks due to drinking water hauling and water storage, developing interventions and educational materials to decrease community risk for harmful drinking water exposures, and providing grant funding. As part of his presentation, Dr. Murphy discussed previous HSB collaborations with Tribal groups. One of the projects involved water hauling on the Navajo Nation. Specifically, 199 drinking water sources were tested. Results revealed bacteria, arsenic, and uranium levels of concern, especially in livestock wells. The wells were labeled as not safe for cooking or drinking and a follow-up study was conducted to see how many people continued to use the wells for drinking. Dr. Murphy said 296 households (with and without access to public water) participated and 246 provided urine samples. Key findings included the following:

- A considerable portion of households haul water including some with access to public water.
- Those that haul water are more likely to be exposed to bacterial contaminants in drinking water.
- Urine uranium levels were higher than US general population, but comparable to other Southwest populations and below levels known to cause health effects.
- Water contamination does not appear to be the sole source of uranium or other chemical exposures found in this population.

After sharing the study results, Dr. Murphy discussed follow-up activities on the individual level, community level, and national level. Among those activities included the development of a Navajo Nation safety campaign, radio ads, and pamphlets.

A second project involved investigating unregulated drinking water use, water hauling, and water storage in Alaskan villages. Dr. Murphy said a lot of the project was similar to what was done on the Navajo Nation, but on a smaller scale. For the Alaskan project, they sampled hauled household and source water samples for bacterial and chemical analysis; collected information about drinking

water use, hauling, sources, storage, and water safety beliefs; and reported results back to households and incorporated them into the ANTHC community education efforts.

Turning his discussion to Clean Water for Health federal grants, Dr. Murphy said the grants in 2011 were called “Enhancing Capacity for Environmental and Public Health Surveillance of Unregulated Drinking Water,” and funding ranged from \$100,000 to \$200,000 per year for 2 to 3 years in duration. He directed the group to the grants.gov website to apply, stating that the grant for next year was expected to be released in the coming months. Dr. Murphy also expressed a desire to develop funding specifically for Tribal groups, but said more interest was needed to show Tribal need and interest. He welcomed feedback and provided his contact information prior to responding to questions.

### Discussion Points

Q: (Lester Secatero) My Tribe, going through IHS, ran a water line through [unintelligible] asbestos. It's a main water line. A rancher now wants to run water through our reservation. I think asbestos is not all that safe these days.

A: (Matthew Murphy) One limitation our group has is we almost have to focus on with private wells and not really community water systems. If you can write up your issue, maybe I or Annabelle Allison can help with getting your concern to the correct person.

Q: (Lester Secatero) We do a lot of testing, but it's hard to get a person with the right training. You do training in that area, right?

A: (Matthew Murphy) We don't do water systems training as much. I'm willing to find the right person for you to talk to.

Q: (Rex Lee Jim) Were there any water sources tested in New Mexico? What is being done about bacterial containments?

A: Utah and New Mexico, yes. We looked at E. coli and others things that are a direct health concern. The hauling process also introduces bacterial contaminants. A lot of the recommendations were to start with clean water and store it in sealed, clean containers.

C: (Chester Antone) Just a reminder to CDC that you should have documented previously from other consultations about water and us not getting any positive movement on this issue. In 2007-2008 we submitted testimony about possible hazards because of pesticides in New Mexico. That was 3 years ago. So, look back there to see what could cause a problem in the future. The 2007-2008 testimony should be on record, so please take a look at that.

### **Social Determinants of Health**

**Leandris C. Liburd, PhD, MPH, MA, Director, Office of Minority Health and Health Equity (OMHHE), Centers for Disease Control and Prevention**

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

Dr. McCree began the presentation by stating that access to medical care, economics, housing, and incarceration are social determinants of health. Reflecting back on her career, she said when she started in the field discussions centered on venereal disease and condoms were sold from behind the counter. She called social determinants of health “complex, integrated, and overlapping social structures and economic systems that influence health status.” Dr. McCree proceeded to show the basic framework used by the World Health Organization (WHO), noting that health equity is the achievement of the highest level of health for all people. Conversely, she said health inequity is a systematic and unjust distribution of social, economic, and environmental conditions needed for health. Furthermore, she said a health disparity is a particular type of health difference that is closely linked with social, economic, and environmental disadvantage. After discussing in more detail factors that influence health, Dr. McCree addressed social determinants and contributing factors as related to HIV.

Dr. Liburd contented that we’ve always known that there was an influence of the social environment on health, yet it has taken years to build a political will and come to a tipping point about the issues in public health. She quoted a poster on the WHO website that asks, “Why treat people and not change what makes them sick?” Dr. Liburd focused her portion of the presentation on Healthy People, saying Healthy People 2020 is the national agenda to improve health in the country and achieve health equity. It provides a set of specific measurable objectives over a 10 year period. Reminding everyone that last December the findings from Healthy People 2010 were released, Dr. Liburd said the the number of objectives have increased. Led by HHS and other stakeholders, Health People 2020 builds on previous decades of work, is grounded in science, and is guided by public input. To that end, she said they want to increase awareness of social determinants of health.

Dr. Liburd shared the mission of Health People 2020, as well as its overarching goals and topic areas (noting that 13 of the 42 topic areas are new). She also commented that the area of “place,” i.e., where people are born, live, learn, work, play, worship, and age, is growing in the literature. Dr. Liburd argued that the only way to address social determinants of health is to bring business, transportation, justice, education, and other sectors to the table to say they are having an impact on health. She discussed ways to use Healthy People 2020, noting that the objectives are still being developed; and she indicated that planning for a Health Disparities Leadership Institute was underway. In closing, Dr. Liburd said she looked forward to feedback regarding relevancy to Tribes and native communities.

### Discussion Points

Q: (Delight Satter) In the graphic, there is no opportunity for Tribal governments to provide input as a government body; is that true? If that is true, can you take the message back to change that?

A: (Leandris Libard) It hasn’t been my understanding that Tribal governments are excluded. So I don’t think there is a separate process, but I’d be happy to take that back.

Q: (Delight Satter) What is the process for this group to help with social determinants of health specific to Tribes? Can we set something up? What is the timeline on social determinants of health?

A: (Leandris Libard) People want it done yesterday. We welcome your participation. We have a Social Determinants of Health workgroup.

C: (Delight Satter) Maybe on the Wisconsin agenda we can carve out time to see what people are interested in.

C: (Chester Antone) This is a long-term deal for us. We lack a lot of infrastructure that you mentioned. I had opportunity to get into this discussion 3 years ago. They had developed a white paper and one of the sticking points was the objectives to measure. It is good to have this on the TAC agenda. A lot of the things you mentioned don't exist on the reservation.

Q: (Rex Lee Jim) Tribal government needs to be included in the grey box on your graphic. What do you mean by evidenced-based? Whose definition of science and evidence are we using? We have ceremonies that heal and enhance health. We need to work together to ensure they are considered.

A: (Leandris Liburd) One article I read a year ago by Michael Marmon said we need to take an open approach to evidence. Historically, evidence based has implied what came out of randomized control trials. Now we think more in terms of strategies that have been implemented, evaluated, and shown to have an impact. That base of literature is still growing. We don't have a menu of interventions that we can put neatly under what we call the social determinants of health. I don't know what would preclude us from including and evaluating what Tribes are doing and documenting it as effective.

C: (Donna McCree) When I think about HIV and the evidence based behavioral interventions, we do publish a compendium around that. These are published studies that have tested interventions. We look at study design, the strength of the evidence, the attrition rate, and other parameters to determine those interventions that are listed in our compendium. We are expanding to look at other outcome measures and we've been funding interventions that we call "home grown," i.e., things being developed in the community that need to be evaluated.

C: (Leandris Liburd) There is a book that we did called Diabetes and Health Disparities and it has case studies (two from native communities) about addressing diabetes through a social determinants lens. I would encourage you to take a look at that.

C: (Delight Satter) Kim will send links to the Marmon article and the book mentioned. The Healthy People is one of the only federal documents that will list by race and ethnicity and always has an American Indian cell. This is important because you can say that we don't have national data on various elements when you write grant proposals.

C: (Unknown): I just wanted to share with you an opportunity through the U.S. Public Health Service. It is the COSTEP [Commissioned Corps Officer Student Training and Extern Program]. This is an internship program that generally happens in the junior year of a person's degree program over the summer months. Internships can be done in any public health related field and a lot of the individuals get placed in the IHS. I went through the program and it changed the course of my life.

### **Social Media**

**Amy Burnett Heldman, MPH, Team Lead, Social Media Team, Electronic Media Branch,  
Division of News and Electronic Media, Office of the Associate Director for Communication,  
Office of the Director, Centers for Disease Control and Prevention**

Ms. Heldman discussed social media at CDC. She began her presentation defining social media outlining its core tenets. She explained that social media allows CDC to tailor health messages to diverse audiences, as well as increase user engagement, share health information in new spaces, listen to audiences, and educate people worldwide about the CDC. Among the CDC's social media strategic objectives include integrating social media in health communications strategies and plans; increasing social media research, monitoring and evaluation; and engaging and interacting with its users. The CDC's social media reach includes Facebook (including an OSTLTS page launched last year), Twitter, Blogs, Text messaging, YouTube, and other tools. Ms. Heldman said that a priority of her branch is content syndication—sharing CDC content with partner websites; and she said mobile/portable content will be a big priority for 2012, with CDC now having an application for iPads and iPhones. After sharing various examples of CDC's social media initiatives, Ms. Heldman discussed the steps to developing a social media strategy:

- 1) Define your target audience(s);
- 2) Determine your objectives;
- 3) Define audience communication needs;
- 4) Integrate social media with goals and objectives;
- 5) Develop messages consistent with your objectives;
- 6) Consider the resources and capacity needed;
- 7) Look at what tools and activities that are available to work best for you;
- 8) Identify the appropriate social media activities to reach your audience(s);
- 9) Identify key partners to collaborate with;
- 10) Define measures of success;
- 11) Create an evaluation plan.

Ms. Heldman also emphasized the importance of creating a promotion plan and repackaging content for a social media audience. In closing, Ms. Heldman said the Health Communicators Social Media Toolkit is available on the CDC website, as well as guidance documents and a metrics dashboard.

### **Improving Cancer Surveillance and Mortality Data for AI/AN Populations**

**Melissa Jim, MPH, Epidemiologist, National Comprehensive Cancer Control Program, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention**

Ms. Jim's presentation focused on work to improve cancer surveillance and mortality data. Before getting into the details of her presentation, she shared a little background information on herself. Notably, she discussed growing up in Shiprock, New Mexico, playing basketball there, and the documentary (Rocks with Wings) and subsequent movie (Edge of America) that resulted from a women's basketball rivalry of which she was a part.

Ms. Jim shared information on the Navajo Nation, including 2010 demographic data. She said race misclassifications too often occur in cancer surveillance. In her work, she said she identifies cases as non-natives and links administrative records from IHS with records from central cancer registries. Specifically, she said she uses the new cancer registries funded by CDC, The National Program of Cancer Registries (NPCR); and the NCI's Surveillance, Epidemiology and End Results (SEER) program. She said she does the IHS linkages every year, noting that some states are linked every

five years because they don't contain CHSDA [Contract Health Service Delivery Area] counties. The results of her work have been used in two reports, although she said Kansas, Vermont, and South Carolina asked not to be included. After doing the linkages, Ms. Jim said she saw that some areas had cancer rates higher than non-Hispanic whites. After working out a deal to use NDI [National Death Index] information, she said they moved to identify data that was misclassified. Ms. Jim said the American Journal of Public Health (AJPH) AI/AN Mortality Supplement will have 39 articles. They took IHS patient data and linked the database with NDI and created two databases. Now they are creating an IHS death registry. Results showed racial misclassification of 19% (with the majority of classifications being "White"); and Ms. Jim showed a chart outlining causes of death for all ages and for infants under 1 years of age. Among the highlights of her presentation included discussion on OK2Share; working with the Great Plains Tribal Chairmen's Health Board; the Cancer among the Navajo report; and linking Tribal enrollment data to produce Tribal cancer summaries. Ms. Jim also discussed various trainings, including work with CRIHB on 2009 Influenza data; and the Summer Research Training Institute for AI/AN Health Professionals, among others. Finally, she talked about the importance of data confidentiality and she concluded that racial misclassifications can be addressed through data linkages.

### Discussion Points

Q: (Brenda Nielson) Can we get a copy of your presentation?

A: (Melissa Jim) Yes.

C: (Brenda Nielson) You can give it to Kim and she will get it to us.

C: (Chester Antone) We have a CDC-funded cancer project, so this would be helpful to us. Thanks for the information.

Q: (Sherrilla McKinley) How do AI/ANs get misclassified as non-Native?

A: (Melissa Jim) When you don't go to an IHS provider, do they ask your race? Often they don't. The cancer registry goes on what is on the medical record.

C: (Sherrilla McKinley) When you first register with IHS you give them Tribal information, so I thought it was automatic.

C: (Melissa Jim) Yes, that is why we are linking to IHS. The cancer registries collect data for anyone with cancer in their state.

Q: (Sherrilla McKinley) Is there something that will be put in place for accurate reporting?

A: (Melissa Jim) It is really up to each provider. A lot of registries are creating a slip of paper for patients that include a race question. Some cancer registries don't do follow-up and others do a follow-up check.

C: (Delight Satter) This is one of the areas I've been working in (misclassifications). Maybe we can go into a deeper discussion about federal dollars regarding classifications and talk about whom isn't doing this and how we can influence the quality of the data.

C: (Greg Holzman) In medical school this is not addressed well. A lot of misclassification happens, even with cause of death.

C: (Audience) I've heard that immigrants have been identified as American Indians.

C: (Delight Satter) They are Native if they are indigenous from Canada. Those from Central or South America are also considered Native.

C: (Audience) I'm talking about people from Pakistan and folks from India.

C: (Melissa Jim) There has been improvements in the census to correct that problem. We work with those data files to look at it the best we can. South Asians may feel out a form one way and it may take time for them to figure out how we classify stuff.

### **Native Diabetes Wellness Program**

**Dawn Satterfield, RN, PhD, Team Lead, Native Diabetes Wellness Program, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Public Health Promotion**

**Larry Alonso, FNP, Traditional Foods Project Lead, Native Diabetes Wellness Program, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Public Health Promotion**

Dr. Satterfield introduced her colleagues in attendance and then shared statistics on diabetes in the U.S. According to the CDC's latest data, 26 million people have diabetes, with one state reporting that one in three American children born in 2000 is expected to develop diabetes in their lifetime. A disease once rare in Indian Country, Dr. Satterfield said AI/ANs now have over twice the rates of non-Hispanic Whites (perhaps one in two for Native children). Dr. Satterfield shared highlights of "River of Hope," which outlines the course of the Native Diabetes Wellness Program. Noting that the balanced budget amendment of 1997 established the Special Diabetes Program for Indians, Dr. Satterfield called IHS a strong partner in the effort. Beginning in 1999, she said CDC gathered Tribal leaders to provide input about diabetes prevention and traditional culture. Among the recommendations offered included: focus on youth, integrate information into school programs, and create enduring stories. After again consulting with Tribal leadership, CDC set up and established the mission of the Native Diabetes Wellness Program. With goals that speak to a balanced life, a community of support, and sharing messages about traditional health, the program spawned the first Eagle book, *Through the Eyes of the Eagle*. Dr. Satterfield had copies of the second book, *Coyote and the Turtle's Dream*; and she indicated that two more books were forthcoming. Additionally, she said there will also be four graphic novels to support the first book; and the ongoing Eagle books exhibit (featuring 90 original paintings and other items), is being connected with the Traditional Foods Project. Dr. Satterfield informed the group that the website for Eagle Book materials for teachers was recently released, containing downloadable materials, posters, PSAs, bookmarks, stickers, coloring books, and other items.

Larry Alonso began his portion of the presentation by discussing the Traditional Foods Project, emphasizing the need for social support and the sharing of knowledge through stories. He said the Traditional Food Project has three domains: traditional foods, traditional forms of exercise, and social support (specifying that social support needs to be culturally relevant). Mr. Alonso said stories were being collected from 17 Tribes; and he shared a video from the Eastern Bands of Cherokee Indians that addressed diabetes and obesity. In closing, Mr. Alonso said the Traditional Foods Project would conclude in 2013; and he directed the group's attention to a poster on the back

wall which highlighted the project, noting that existing data demonstrated the transformation of various communities.

### Discussion Points

Q: (Brenda Nielson) Can we get a copy of the video?

A: (Larry Alonso) I will put you in contact with the Eastern Band of Cherokee Indians.

C: (Brenda Nielson) Yes, please provide us with that information.

C: (Rex Lee Jim) One initiative is for the Navajo to get in touch with Martha Stewart and others, so maybe through this project we can get on one of those programs.

### **Day 2 Wrap-Up**

Dr. Holzman thanked the meeting participants for what he called a fantastic couple of days. Noting that progress had been made on some items, he said there is still much to do. Through collaboration, and with help from Tribal leaders in prioritizing issues, he said items could be moved forward. After sharing highlights from the day, Dr. Holzman reminded everyone about the following day's consultation session. Ms. Cantrell provided logistical information pertaining to that consultation; and Ms. Bohlen distributed documents for the session.

The meeting ended with Chairwoman Nielson thanking the group for being patient with her as she served as Co-Chair for the first time, and Chairman Antone providing the closing blessing.

## **Appendix A: Participant Roster**

### **Tribal Advisory Committee (TAC) Members**

Chester Antone, Tohono O'odham Nation  
Stacy A. Bohlen, Sault Ste. Marie Chippewa; National Indian Health Board  
Joe Bray, Choctaw Nation, Special Project Coordinator  
Jay Butler, MD, Alaska Native Tribal Health Consortium  
Connie Hilbert, MS, RS, Mohegan Tribe  
Gayline Hunter, California Rural Indian Health Board  
Rex Lee Jim, Navajo Nation  
Sherrilla McKinley, Inter Tribal Council of Arizona, Inc.  
Brenda Nielson, Northwest Portland Area Indian Health Board, Quileute Tribe  
J.T. Petherick, JD, MPH, Cherokee Nation  
Lester Secataro, Albuquerque Area Indian Health Board, Inc.

### **Centers for Disease Control and Prevention**

Annabelle M. Allison, National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry  
Larry Alonso, FNP, Division of Diabetes Translation  
Kimberly Cantrell, Office for State, Tribal, Local, and Territorial Support  
Carlyn Collins, MD, MPH, Laboratory Science, Policy, and Practice Program Office, Office of Surveillance, Epidemiology and Laboratory Services  
Rear Admiral Scott Deitchman, MD, MHP, National Center for Environmental Health and Agency for Toxic Substances and Disease Registry  
Michael Franklin, Financial Management Office  
Amy Burnett Heldman, MPH, Office of the Associate Director for Communication, Office of the Director  
Gregory S. Holzman, MD, MPH, Office for State, Tribal, Local, and Territorial Support  
Melissa Jim, MPH, National Center for Chronic Disease Prevention and Health Promotion  
Rachael Johnson, Public Health Associate Program  
Leandris C. Liburd, PhD, MPH, MA, Office of Minority Health and Health Equity  
Donna McCree, PhD, MPH, RPh, Division of HIV/AIDS Prevention  
Carol J. McElroy, Financial Management Office  
Mark Miller, National Center for Environmental Health  
Judith Monroe, MD, FAAFP, Office for State, Tribal, Local, and Territorial Support  
Matthew Murphy, PhD, MS, National Center for Environmental Health  
Lydia Ogden, PhD, MPP, MA, Health Reform Strategy, Policy, and Coordination Office, Office of the Associate Director for Policy  
Matthew Penn, JD, MLIS, Public Law Program, Office for State Tribal, Local and Territorial Support  
Delight Satter, MPH, Office of State, Tribal, Local and Territorial Support  
Dawn Satterfield, RN, PhD, National Center for Chronic Disease Prevention and Public Health Promotion