CDC Tribal Consultation Advisory Committee

Meeting Minutes

November 2 and 3, 2006 – Atlanta, GA

Members/Alternates Attending
Jefferson Keel, Board Chair - Oklahoma Area
Linda Holt, Board Co-Chair – Portland Area
Joe Finkbonner, NPAIHB- Alternate
Jerry Freddie – National Indian Health Board
Barbara Bird – California Area
Evelyn Acothley – Navajo Area
Alice Benally – Direct Service Tribes Advisory Committee
Sandra Ortega – Tucson Area- Alternate
Randolph Runs After – Aberdeen Area- 2nd Alternate
H. Sally Smith – Alaska Area – 2nd Alternate
Joe Bray – Tribal Self Governance Advisory Committee (Proxy for Mickey Peercy)
Brenda Shore – Nashville Area - Alternate
JT Petherick, Oklahoma Area - Alternate
Amadeo Shije – Albuquerque Area (afternoon arrival)
Wendie Murray – Tribal Self Governance Advisory Committee – 2nd Proxy

Areas and Organization Not Represented
Phoenix Area
National Council of American Indians

CDC/ATSDR Staff
Mike Snesrud, CDC
Ralph Bryan, CDC
Walter William, CDC
Heather Brink CDC
Leslie Campbell, ATSDR
Kris Larson, ATSDR

National Indian Health Board Staff
Deborah His Horse is Thunder, contracted by NIHB
Helen Canterbury, NIHB
Stacy Bohlen, NIHB

Materials Distributed
1) TCAC Membership contact information, 2) Draft TCAC Charter, 3) Copies of 4 Eagle Books developed by Division of Diabetes Translation, 3) The Eagle Book Series: A Guide for Educators and Communities, 4) A Office of Smoking and Health Training Manual: American Indian and Alaska Native Adult Tobacco Survey Interviews, 5)

Background for Crisis and Emergency Risk Communications (CERC) Training, 6) Packets of Index Cards with CDC's 80 Objectives for Achieving Greater Health Impact, 7) Six Power Point presentations:

- CDC Native Diabetes Wellness Program
- Agency for Toxic Substance and Disease Registry (ATSDR)
- National Center for HIV, STD, and TB (NCHSTP)
- CDC's Health Protection Goals: Partner & Public Engagement
- Coordinating Office for Terrorism Response: An Update for TCAC
- CDC/ATSDR Financial Management Office: Budget Briefing

Additional information referred to during meeting:
1) COTPER Transition, 2) Division of State and Local Readiness Project Officers by Groups, 3) 2006 Program Consultant Assignments, 4) FY2006 CDC Budget and Goals: FMO and OSI, 5) Tobacco Programs, 6) Brief About HHS Barriers Workgroup Charge, 7) CDC Focus Group Report 8) Barriers Final Workgroup Report 8) Article on Diagnosed Diabetes Among American Indians and Alaska Natives Aged <35 Years --- United States, 1994--2004

Welcome

Chairman Jefferson Keel welcomed everyone attending the meeting. He apologized for the delay in starting the meeting and assured everyone that this was not acceptable and that in the future meetings will begin on time. He asked Mr. Jerry Freddie to begin the meeting with a blessing. Following the prayer, Chairman Keel asked each person to introduce him/herself to the group.

Approval of Minutes

The record of the meetings of October 9 and 10, 2006 were presented for approval***. H. Sally Smith made a motion to approve the minutes. Jerry Freddie seconded the motion. Motion is approved by consensus.***

Opening Comments by Dr. Julie Gerberding, Director of CDC

Dr. Gerberding welcomed the Advisory Board to CDC. Chairman Keel asked each of the Advisory Board members to introduce themselves to Dr. Gerberding so that she would get a sense of the group. She thanked everyone for coming to Atlanta and noted that this was an important occasion for CDC.

She said CDC staff were interested in how to work together. CDC has been working in a vertical direction; their strengths are in science (e.g., research, programs, guidelines, and recommendations in health). They must also have leadership to work across boundaries throughout the silos of CDC and throughout networks beyond CDC. They are calling this meta-leadership. This leadership is more about communication and collaboration than commanding and directing. It is more about idea sharing. The Robert Wood Johnson Program is supporting CDC to develop and achieve this type of horizontal leadership that can be applied to our partnerships to develop meta-leaderships at the local, state, and regional levels.

If CDC wants to solve the big problems, it must look at how it was successful in the past. One example is polio: it was a big investment of people, money, engagement, and meta-leadership (including governments and international organizations) and of networks to make it work. The framework is to establish a big goal and make a big commitment over a long period of time. CDC's goal is to bring a lot of people together with a common concern to make a difference by developing extensive networks. CDC has made a conscious decision to concentrate on fewer things but with more focus to make a difference.

Chairman Keel focused the discussion on the purpose of this Advisory Committee as providing a setting where tribal representatives and CDC staff will discuss urgent public health needs in AI/AN communities and collaborative approaches through the consultation process that will result in improved flow of resources to the user level. He posed the question, "How can this Committee advise you and your staff to get resources to the local level, especially when there is a difference in the priorities?" Linda Holt reinforced this concern with her comment about the difficulty in getting resources to the grassroots level. Dr. Gerberding indicated that this is actually a generic concern, not only for tribal communities but for many communities, and is a good example of the need for meta-leadership. The first step is to do an analysis of the current funding, the goals and objectives, and the investment of the stakeholders. One way of doing this is looking critically at the new cooperative agreements being established and ensure that outcomes are result-oriented. Dr. Gerberding acknowledged that the goals management process is a long-term process that is evolving. Linda Holt asked that tribes have a seat at the table during the negotiations to assure that the States and other stakeholders are responsive and held accountable for distribution of CDC resources and services.

Jerry Freddie also expressed a need for effective communication of needs and concerns to Native people, especially those whose primary language is that of their Tribal Nations. Tribes are knowledgeable and involved in issues affecting their tribal members and want to be a part of the decision-making process such as that of CDC's. Federal agencies e.g., CDC need to recognize that tribes are societies within the larger society. Dr. Gerberding responded to say that CDC initially focused on science and then on programs, and now it is also including marketing so that the broader society will better understand the relevancy of the science to their lives.

Discussion of Charter

At the last meeting a sub-committee was appointed to develop a draft charter to be shared with the entire TCAC to move deliberations along in the adoption of a TCAC Charter. The Advisory Committee reviewed the draft charter presented by the sub-committee section by section as a group. After a very lengthy discussion over different periods of time allotted during both days of the TCAC meeting, the Committee achieved consensus in its development. Some changes that were made included increasing the number of advisory committee members from 15 to 16, adding and clarifying the NIHB role and other roles and responsibilities, and adding timelines as appropriate. The changes were all incorporated into the final TCAC Charter. Furthermore, it was recommended that a

glossary of terms be developed so that all the abbreviations and acronyms often used are defined.

***Evelyn Acothley made a motion to accept the charter as revised by the TCAC. Alice Benally seconded the motion. Motion passed unanimously*.**

Presentation – Overview of the Agency for Toxic Substance and Disease Registry (ATSDR) and Office of Tribal Affairs (OTA)

Dr. Howard Frumkin, Director of the National Center for Environmental Health (NCEH)/ ATSDR and Leslie Campbell, Interim Tribal Coordinator, Division of Health Assessment/OTA/ATSDR presented an overview of ATSDR and their OTA. ATSDR is a sister agency to CDC that has for some time had an OTA. During the past few months there have been some changes, but the commitment to AI/AN tribes and communities remains. ATSDR's mission is, "To serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposure and disease related to toxic substances."

The OTA serves as a central conduit for tribes to access agency programs and services, assists ATSDR in responding to Presidential executive orders and federal mandates concerning tribes, develops in collaboration with tribes, ATSDR American Indian/Alaska Native policies, and coordinates programs and projects to support tribal-specific public health needs.

ATSDR has 10 regional offices and staff often co-located with other federal agencies. It has four divisions: regional operations, health studies, toxicology & environmental medicine, and health assessment & consultation. The OTA does provide some direct assistance to tribes, tribal organizations, and tribal health programs through environmental public health evaluations that are chemical and exposure pathway specific by conducting community specific tribal consultation. ATSDR has staff who are trained in cultural and legal aspects of government-to-government relations.
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ATSDR/OTA funds Gila River Indian Community, Dine College, Turtle Mountain Community College, Inter-Tribal Council of Michigan directly through cooperative agreements. They also have capacity-building programs that provide resources and technical assistance, improve tribal capacity to address environmental public health issues, and research to reduce and prevent exposures.

TCAC raised several issues to Dr. Frumkin and Ms. Campbell. Chairman Keel, as a veteran of Vietnam, expressed concern about the effects of chemicals such as Agent Orange. He indicated that there is also environmental damage to the lakes in Oaklahoma. Co-Chair Holt from the Northwest expressed concerned about the environmental damage to the fish. She also expressed concern about meth labs and the resulting exposure to the children and unborn to this and other chemicals such as those mentioned by Chairman Keel. She articulated a need for greater communication and education about the agencies' resources.

H. Sally Smith raised the issue of the need for seamlessness across CDC. Dr. Frumkin responded by stating that the fact that ATSDR has an Office of Tribal Affairs that was intentionally created by no accident of history and they are committed to maintaining it unless they are told by Indian Country that Tribes desire only one office for both CDC and ATSDR. ATSDR will listen and comply with a recommendation from the Tribes. Dr. Williams indicated that there has been discussion within CDC/ATSDR about the need for a strategic plan to be more responsive to identified needs of Tribes and these discussions are continuing.

Randolph Runs After reinforced the need for environmental officers at the local level. Dr. Frumkin indicated that he was committed to encouraging more people to become involved at the local level. He also encouraged individuals to contact him to discuss issues further.

Contact information for the Office of Tribal Services:

Leslie Campbell, LCampbell@cdc.gov 404-498-0473
Kris Larson, KLarson@cdc.gov 404-498-0527

Presentation – Division of Diabetes Translation, Native Diabetes Wellness Program (NDWP)

This presentation was conducted by Lemyra BeBruyn and Dawn Satterfield. The NDWP was developed in a culturally responsive framework specific to AI/ANs. The program attempts to influence policy at the national and international levels for Native communities. It focuses on a circle of life with one generation helping other generations and all working in the local community.

The NDWP within CDC's Division of Diabetes Translation is a circle of people and organizations working together to decrease the diabetes epidemic in tribal nations. With social justice as its founding principle, the Wellness Program is committed to reducing the gaps in health equity so starkly revealed by diabetes. The NDWP believes communities can walk the paths of wellness together, respecting both Native and western science. The Wellness Program is advised by the Tribal Leaders Diabetes Committee (TLDC).

Diabetes is an area of great concern as one in three Americans born in 2000 is expected to develop diabetes in their lifetime and American Indians have an especially high rate of diabetes. The NDWP was advised by the TLDC to develop some children's books on diabetes similar to the Golden Books. The idea of the books was to teach children about promoting health and preventing diabetes using the tradition of storytelling. The *Eagle Book* series includes four vividly illustrated books for children in which a wise eagle reminds children of traditional ways to grow safe and strong and prevent diabetes. The objectives of the *Eagle Books* are: to inspire healthy lifestyle choices through a series of vividly illustrated children books which demonstrate good nutrition and physical activity; to reawaken the enjoyment of physical activity and promote healthy eating that contribute to the prevention of type 2 diabetes; to encourage children to learn the traditional ways of

their people, including living healthy, staying active and being grateful for the gifts of Mother Earth.

The Division of Diabetes Translation, through a new Program initiated in 2005 called "Health Promotion and Diabetes Prevention Projects for AI/AN Communities: Adaptations of Practical Community Environmental Indicators," began funding eight tribal programs directly. The projects include Salish Kootenai College, Tulsa Indian Youth, United American Indian Involvement, and the Lummi, Ho-Chunk, Stockbridge Munsee, and Southern Ute Nations.

Office of Smoking and Health (OSH) Overview of Current Partnerships with AI/AN Tribes and Organizations

Barb Park, Deputy Chief or Program Services Branch/OSH along with Ralph Caraballo and Sara Mirza, Epidemiologists and Stacy Thorne, Public Health Analyst offered an overview of the OSH.

In 2000, the OSH began funding seven Tribal Support Centers. In FY 2005 a new round of candidates vied for Tribal Support Center cooperative agreements. This Request for Proposals differed from the first round of Tribal Support Center funding in that AI/AN tribes and tribal organizations could compete for either capacity-building funding or implementation funding. As Indian Health Service (IHS) does not contain a public-health component, CDC/OSH recognized that many AI/AN tribes suffer from a distinct disadvantage in tribal capacity and infrastructure in the area of population-based commercial tobacco control and prevention. Thus, funding was set aside for building such capacity. In addition, CDC/OSH wanted to assist in the sustainability of previously funded Tribal Support Centers. To that end, monies were set aside for implementation of cooperative agreements. The implementation programs are venues through which culturally competent AI/AN-developed promising practices are implemented inter-tribally and then scientifically evaluated. Under the new announcement, OSH is working with four new capacity-building organizations: Black Hills Center for American Indian Health, California Rural Indian Health Board, Cherokee Nation, Indigenous Peoples Task Force and three implementation programs: California Rural Indian Health Board, Muscogee Creek Nation, and SE Alaska Regional Health Consortium.

Each project has four goals: 1) prevent initiation among youth, 2) promote quitting among adults, 3) eliminate exposure to second-hand smoke; and 4) identify and eliminate disparities among populations. Each goal also has four components: a) community interventions, b) counter-marketing, c) policy/legislation; and, d) surveillance/evaluation.

Barb Park gave a number of examples of what tribes and tribal organizations were doing in their projects, including developing public service announcements in their Native languages, establishing tribal proclamations, and the education and training of state collaborators.

H. Sally Smith raised the question regarding the tobacco money that is going only to the States and asked why the funds could not go to Tribes as well. Ms. Park responded that

the States were working with the Tribes. JT Petherick requested clarification regarding the source of the funds and the response was that the vast majority of the money was from the tobacco companies. H. Sally Smith recommended that the block grants going to the states need to be reformulated to include tribes.

Sara Mirza reported that there is high adult Native tobacco use. In 2000, a meeting was held to redesign the CDC adult tobacco survey to make it be more culturally relevant to American Indians. This instrument was tested in 10 tribes and one inter-tribal organization and is just now completing the testing process. She assured TCAC that the data collected belonged to the tribes. A training manual was provided to the TCAC members with encouragement to share it with other tribes. Stacy Thorne reported that all tribal entities who implemented the survey were brought together to discuss next steps and lessons learned. They are now in the process of applying the results of the survey in doing work within their local communities. OSH is now working with the Alaska Native Tribal Health Consortium to develop an AN-specific survey and training manual that is more specific to the AN villages.

Contact information for further information:

Sara Mirza -- SMirza@cdc.gov
Stacy Thorne – Sthorne@cdc.gov
Barbara Park – bpark@cdc.gov Telephone: 770-488-1094

Office of Strategy and Innovation (OSI) Update on Goals and Management Process

Peter Briss, Office of Strategy & Innovation (OSI), provided an updated on the CDC goals management process. He reported that CDC has developed six Strategic Imperatives and four overarching Health Protection Goals along with some 82 objectives. The four goals are: 1) Healthy People in Every Stage of Life, 2) Healthy People in Healthy Places, 3) People Prepared for Emerging Health Threats, and 4) Healthy People in a Healthy World. Currently CDC has formed Goal Action Teams who have begun working on developing Goal Action Plans which will each have key strategies, actions, and measures (with targets). The Goals Action Plans are anticipated to help CDC to:

- Better prioritize participation with stakeholders
- Measure and be accountable
- Be more transparent
- Find out what is working through research and get more rigorous about what things cost.

CDC has held six public engagement meetings around the nation. Mr. Briss described the on-going process was a deliberate attempt to hear from communities about how they prioritized the proposed objectives. Communities, including the AI/AN, provided input to CDC on such questions as, why is this health issue important? How are different groups or communities affected? Is it feasible to make progress on the objective today, or does it present a research opportunity? Is the objective consistent with CDC's mission, core values, and interests? OSI understands that all communities are asking how

this Goals Management Process will make a difference to them, especially in distribution of resources and prioritization of its work.

The outcome of the discussion was that the TCAC is interested in having on-going dialogue with CDC and OSI as the process continues to evolve. TCAC wants to have an opportunity to review and give recommendations to CDC as the Goal Team Action Plans are developed. Peter Briss communicated that a reasonable time to have another discussion would be early next spring which will allow OSI to gather additional information, develop plans, and analyze potential impact. TCAC encouraged CDC to determine how to have pre-discussions/consultation with tribal Nations rather than having post discussions, i.e. after the fact. TCAC and tribal Nations want to be consulted for recommendations and input up front, not just asked to affirm what is decided.

Mr. Briss will find out if the TCAC will be able to review the internal report documents prior to public release so that the Committee can have meaningful input.

Overview of the CDC Budget Process

Mr. Robert Curlee, Deputy Director of the Financial Management Office (FMO) presented a briefing of the CDC budget process. Mr. Curlee shared that Bill Nichols, the new Director of FMO, could not be present with the TCAC for this discussion. Rob Curlee stated that the FMO has several areas of responsibility: accounting, compliance with the CFO act, financial services, audits, financial systems, budget execution (allocation of funds, track funding, how it is expended, forecasted), budget formulation, and public health policy (Congress). They have approximately 300 staff, many of whom are located in Atlanta.

Mr. Curlee presented a slide that illustrated the overlap of the funding cycles. CDC is working on three budget years at any given time. As of September 30, CDC has finalized FY 2006. Congress is working on appropriations for FY 2007, and we are in the planning process for FY 2008. The Budget process includes four major phases: Planning, Formulation, Presentation, and Execution.

- **Planning:** Selection of Program Initiatives; CDC Director (ELB/MC) determines funding & priorities; Development of GPRA & Strategic Plans
- **Formulation:** CDC/HHS/OMB Budgets, President's Budget (CJ), Secretary's Budget Council/OMB presentations to justify budget
    - Submissions include performance information (due to Budget & Performance Integration), beginning with FY 2006 HHS Submission.
    - Performance information includes Full Cost, GPRA and PART measures/updates.
- **Presentation:** Committee hearings; Q's & A's; House, Senate, and Conference reports; Appropriation bill
- **Appropriations:** President's Budget only a proposal/Congress makes decisions/many changes. CDC appropriation from Labor/HHS/Ed bill, while ATSDR's appropriation is from the Interior, Environment and Related Agencies bill.
- **Execution:** Apportionments, Spending Plans, Allotments, Allowances.

Mr. Curlee explained terms such as "pass back" and "earmarks." The planning for FY 09 has started now. The best time to consult with CDC to influence the budget of HHS is before March, such as January or February. The question was raised regarding how the TCAC can influence the current budget process for FY 2008 given that the TCAC has just been established and this particular meeting is the first opportunity to have any dialogue with CDC specific to the budget and the needs of Indian Country.

CDC is within Department of Health and Human Services. The discretionary funding for CDC is 9% ($9.4 billion) of a $70.9 billion budget. Most of CDC dollars comes already earmarked for specific projects/programs. CDC is subject to mandatory funding and rescissions as well e.g., 1% over the past year.

The TCAC discussed the issue of processing federal funding through States and the challenges that it has presented to tribes. Several examples were cited where States were exceptionally resistant to providing needed services or even releasing funds specifically for Native people/programs. CDC needs to find ways to work more directly with tribes rather than going through States, especially with respect to the government-to-government relationship.

The current CDC budget environment indicates that there are increasing demands on the budget. There are global and domestic threats e.g., the recent e-coli outbreak and Hurricane Katrina. There is a constraint on existing resources and limited flexibility in targeting resources to areas for greatest health impact and need. This results in an overall decline in discretionary funding with minimal program increases. There is an emphasis on pandemic influenza, emerging infectious disease, rapid HIV testing, immunization and preparedness. CDC has targeted program reductions and eliminations.

The TCAC engaged in discussion with Mr. Curlee regarding the CDC budget and the budget process. The TCAC wants to continue to receive additional budget information as the process moves forward. They asked FMO for assistance in identifying specific opportunities and the appropriate timeline to be able to influence and impact CDC's budget process.

Procurement and Grants Office (PGO)

Elmira Benson, Acting Deputy Director, was asked to provide an overview of the eligibility of its grants and funding opportunities. She has been the Acting Deputy Director for three days. Ms. Benson stated that all of the program announcements are posted on grants.gov. All submissions are encouraged electronically, although alternative means of submissions are also included in the announcements. If anyone has difficulties or questions, she can be reached at telephone (770) 488-2656.

Ms. Benson was asked if any American Indians are included in the screening of applications for funding. The TCAC was assured that American Indians are included in the screening/review process. CDC does try to include American Indians from within CDC, other federal agencies, or if necessary non-Native people who have had experience

working with tribes. There are currently 66 funded projects, so there are 66 project officers who are active with tribes or tribal organizations at this time.

8(a) program makes awards up to $5 million. There is more flexibility in contracts than grants. Curtis Bryan is the Small Business Advisor.

OMHD/FMO Ai/AN Financial Portfolio Process

Dr. Bryan reported that the Office of Minority Health and Health Disparities (OMHD) is trying to track all the CDC funding that is being directed to American Indian/Alaskan Native Programs. The specific areas that they are looking at are:

1. **AI/AN Awardee:** Competitively awarded programs (i.e., grants, cooperative agreements) where the awardee is a Tribe, Tribal health board or coalition, Tribal organization, Alaska Native organization, urban Indian Health program, or Tribal college/university.

2. **Extramural AI/AN benefit**: Competitively awarded programs where the purpose of the award is to primarily or substantially benefit AI/ANs; however, the awardee is not a Tribal organization as defined in #1 above (e.g., state health departments, academic institutions). *(Note: "primarily or substantially" is defined as 50 percent or greater devotion of funds/efforts to AI/AN populations).*

3. **Federal AI/AN benefit:** Federal Intra-Agency Agreements where the purpose of the agreement is to primarily or substantially benefit AI/ANs (e.g. with IHS).

4. **Intramural AI/AN:** Intramural programs whose purpose is to primarily or substantially benefit AI/ANs; this category includes costs (e.g., salary, fringe, travel, etc.) associated with CDC staff or contractors whose time/effort primarily or substantially benefit AI/ANs.

5. **Indirect AI/AN:** Service programs where funding for AI/ANs can reasonably be estimated from available data on the number of AI/ANs served. This category includes the Vaccines for Children program, where the amount of funding benefiting the AI/AN population is reasonably estimated by taking the proportion of clients served who identify themselves as AI/AN via patient encounters, and applying that proportion to the total funding for the program.

The question was raised regarding how does it get determined how money will get spent in each category? Priorities are determined by overall agency goals and then at the programmatic level. Several different programs can be addressing the same health issue e.g. STD, and they are now putting in place a database that would allow access to data by all the programs that are addressing any one health issue.

One strategy to increase funding for Indian country would be to aggressively approach each program process to educate them on the needs of Indian country. It was also suggested that the report coming from the Committee could be directed specifically to programs regarding the needs of Indian country.

Overview of Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER)

Susan True, Branch Chief, Division of State and Local Readiness, presented an overview of her office. This is a new division within CDC and she has been in the division since May, 2006. The program's mission is to "Prevent death, disability, disease and injury associated with urgent health threats by improving preparedness of the public health system, the healthcare delivery system and the public through excellence in science and services." The division was prompted into existence by September 11th and its initial focus was bio-terrorism but it has since expanded that to all hazards (e.g., biological, nuclear/radiological, chemical, trauma, natural events).

COTPER is a central point of contact with other federal agencies that connect to preparedness in some way, for example, Department of Homeland Security and HRSA. They are setting up a matrix that will allow consumers to know which agency would be the best source to address their specific needs.

Some of the COTPER programs include the Public Health Emergency Preparedness Cooperative Agreement (including pandemic influenza supplements), Centers for Public Health Preparedness (CPHC) Cooperative Agreement; Partnerships (funded and non-funded); Assessment and evaluation of preparedness activities, outcomes and progress. The Public Health Emergency Preparedness Cooperative Agreement provides funds to 62 grantees in all states and promotes the measurement of preparedness. The measurement of preparedness is difficult as there is no baseline to use.

Tribes need to review the State's Public Health Emergency Preparedness Plan and know the State's Preparedness Director to ensure that the Tribes' interests are included. Ms. True recommended that tribes participate on preparedness advisory committees and subgroups on mass vaccinations, sheltering, alternative care sites, and/or vulnerable populations. She also recommended that each community have an emergency plan and be involved in exercises and drills.

The questions were posed to Ms. True regarding who determines if a State has meaningful participation of tribe. She indicated that in the past that they simply asked if the State did and the response was generally affirmative. They now plan to ask for definition of meaningful participation of tribes from States. She also indicated that the TCAC could help with this process.

Regarding COPTER funding, approximately 34% of the funding received by the States will be distributed to local entities ($229,123,771). Approximately, 1% will be distributed to tribes ($4,116,224). This amount is not enough. The question regarding how these figures were derived were raised and discussed. It was agreed that COPTER needs to more conscientious effort to track the funds that go to American Indians/Alaskan Native communities.

Ms True asked the TCAC to assist her to fill a position with a background in preparedness as well as additional positions.

Overview of the National Center for HIV, Viral Hepatitis, STD, and TB (NCHHSTP)

Dr. Hazel Dean, Acting Deputy Director gave a brief overview of the National Center for HIV, Viral Hepatitis, STD, and TB. They have six divisions; this Center has experienced level funding. Global aids funding has had a increase of funding while all other programs have decreased. Key challenges include diverse epidemics, trajectories, but common risk populations.

Some key achievements include the incorporation of the Division of Viral Hepatitis in NCHHSTP, new hepatitis B vaccine recommendations, enhancing hepatitis B vaccine implementation in the U.S., launch of the revised syphilis elimination effort, 2006 STD treatment guidelines, HPV vaccine licensure, revised HIV testing recommendations, and continued recommendation of the President's Emergency Plan for AIDs Relief. Their priorities are to accelerate elimination TB, syphilis, and prenatal HIV, and to enhance implementation of vaccine preventable STD.

The programs in AI/AN communities include capacity-building assistance to improve delivery and effective of HIV prevention services in CA. Funding community-based organizations to conduct HIV/AIDs in Alaska and the Native American Community Health Center. Under the STD Prevention Capacity in Indian Country, two projects were funded, one in the Portland Area and one in Navajo (institutionalized STD screening in Navajo detention centers and behavioral health outreach clinics). NCHHSTP's Public Health Workforce Development has supported the Dine College development of a 2 year Associate of Science degree program in public health as well as the AISES Summer Internship Program.

It was pointed out that a number of these programs were ending which raised the question about the future of these programs and commitment of NCHHSTP to HIV and STD Prevention Programs in Indian Country. Dr. Dean indicated that the budget for FY 07 is not available yet. STD programs are marked for cuts so the future is highly questionable. Regarding the Dine College's project, the funding comes from Health Disparities and they are working hard to continue the funding for this program. A problem related to Dine College has been how to get the money out through a recognized vehicle and they are continuing to look for a solution. It was suggested that the TCAC could carry a strong message on behalf of Indian Country about the importance of this Center's prevention programs as they determine their recommendations to influence CDC's budget process. Dr. Dean was asked to further educate the Committee about how they could specifically increase access to NCHHSTP's resources and program, especially those that go to states with significant Native populations.

Chairman Keel commented that the TCAC needs more education and to determine how to formulate more effective questions to engage in appropriate CDC senior staff in discussions. The CDC representatives have all been very willing to help the TCAC but

the information has been overwhelming. It is now up to the TCAC members to do their homework to know how to be more effective. It was suggested by Dr. Williams that the as new grants funding becomes available the grant language could be reviewed by the TCAC so that model language could be provided to all the CDC divisions. Mike Snesrud suggested that more could be done with the tribal colleges such as the work with Dine College as that is the only effort at this time. Internships for Native students could be further developed as NCHHSTP is one center that has have provided numerous undergraduate and graduate fellowships that have established a long term relationship allowing several Native student to obtain MPH and doctoral degrees.

Crisis and Emergency Risk Communications (CERC) Training Opportunity for Indian Country

KD Hoskins presented on Crisis and Emergency Risk Communication Training Opportunity for Indian Country. She has been working on updating this training since 2002 and there is an effort to focus a special training for AI/ANs for 120 plus participants. They had some participation at other trainings of American Indians/Alaska Natives but have not felt it has been enough to assure training needed have been provided.

They are seeking 10 participants from each region and will pay for their participation. Ms. Hoskins asked TCAC to select the host city and the 10 participants by Thanksgiving. The training will take place early next year. She apologized for the short notice but hoped TCAC would provide the guidance and assistance.

The training objective is to “train the trainer” so that the participants will be certified to return to their communities to train others on the pan flu epidemic and emergency preparedness. The participants have been a wide range of people from community hospital workers to regional directors.

TCAC discussed several locations and it was suggested that the members then e-mail their suggestions to the Chairman with a first and second recommendation. It was also suggested that possible dates be included.

ADDITIONAL Information shared by ATSDR

Leslie Campbell from ATSDR shared that NCEH/ATSDR is sponsoring a conference December 4-6, 2006 in Atlanta. This 2006 National Environmental Public Health Conference includes one session on Challenges of Environmental Health in Indian Country. She invited a couple of TCAC representatives to attend and stated that ATSDR will pay the travel costs. It will be held at the Hilton in downtown Atlanta, GA. Anyone interested could e-mail Chairman Keel or Co-Chairwoman Holt and express their interest. She requested that the names be sent to her by Nov. 10th.

Suggested Focus Areas for TCAC - 2007

Grants & Contracts

There are grants and cooperative agreements available through CDC and as resources continue to dwindle for tribes, it is important to understand how AI/AN tribes and organizations can access these public health prevention resources and successfully compete to receive the awards. TCAC need to increase their level of knowledge about what is available in terms of grants and contracts to share with Area Health Boards, tribes, and other tribal organizations. There is a need to know how to access and obtain this information as soon as it becomes available to allow more time in completing the application process and be afforded the opportunity to ask questions and seek out TA as needed.

Training

This is also important to tribal health staff to improve the quality of health services to tribes. CDC has numerous student and professional training programs that can be utilized in building the public health capacity of tribes and diversifying the overall public health workforce at the tribal, state, and federal levels.

Education Process

TCAC needs to determine how to become more knowledgeable about various CDC program areas such as diabetes, smoking or preparedness and request that Center provide a more in-depth session to TCAC that would allow TCAC members to more thoroughly understand the resources and services available to address an identified need in Indian Country.

Budget

How can TCAC inform and provide input and specific recommendations to CDC budget formulation process in a timely and appropriate manner that can be tracked and measured? Question has been raised as to the TCAC desire to develop a CDC AI/AN strategic approach and plan and what steps need to be taken to enable this to happen.

TCAC desires to continue discussion with FMO, PGO, and key Centers about how they can influence and increase access to CDC resources.

TCAC wants to review and understand CDC AI/AN Portfolio.

Mentoring Programs

A good orientation to CDC culture is needed to assist TCAC in asking the right questions and making recommendations that will address urgent public health needs in Indian Country. There is a huge need to increase the number of Native public health professionals to serve at the local tribal level and also at the state and federal levels.

CDC Service Delivery

CDC Centers, Offices, and Divisions have many different partnerships, including a long-term relationship with the states. Even though CDC funds the states to do certain activities within their states, often activities that will reach the most vulnerable populations do not reach AI/ANs. Tribes often have no relationship or a relationship that is not guided by the tenets of the HHS or CDC Tribal Consultation Policy. Tribes do not necessarily know who to talk to at the state in general about public health issues and definitely do not know who to contact about a categorical issue (emergency preparedness, diabetes, injury, etc.). A significant amount of CDC funding goes directly to the States and the tribes and states have often been at odds with one another, sometimes in adversarial relationships. What can CDC do to help assure funds allocated to State health departments actually filter down to tribes? How can tribes increase their access, improve relationships, and identify common goals with the States? Dr. Bryan suggested approaching this on a state-by-state basis. For instance, several states that have a significant Native population have a Senior Management Official assigned to them to be a Portfolio Manager. Dr. Williams suggested that these Senior State Managements Officials have tribal activities be included in their performance evaluations. Chairman Amadeo Shije suggested that CDC and TCAC work together to recruit more AI/AN people to work in these various liaison positions.

Next Meeting

The group discussed the possible dates for the next TCAC meeting. It was suggested that the TCAC meet in Albuquerque, NM the week of January 29, 2007 with travel on Monday, January 29 and the meeting to be held on January 30-31, 2007. It was suggested that CDC follow-up with Amadeo to see if the meeting could be hosted at the All Indian Pueblo Council complex. Depending on availability, Dr. Ralph Bryan will also check on meeting facility space at the Albuquerque IHS Headquarters.

Chairman Keel asked the group to begin thinking about the first bi-annual consultation conference. One possibility and strong suggestion made was to plan and hold the second quarter meeting and first bi-annual consultation session in conjunction with NCAI's semi-annual conference which will be in Anchorage, AK in June. This can be discussed further at the next meeting.

Meeting Wrap Up

Chairman Keel asked that everyone complete the evaluation forms and turn them in to Mike or Ralph.

Chairman Keel thanked the CDC staff for all the presentations and especially, for Dr. Gerberding's visit and dialogue with the TCAC.