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

Tribal Consultation Advisory Committee (TCAC) Meeting

January 27, 2010
Orientation Session Summary

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Acronyms

ADP	Associate Director for Program
ADS	Associate Director for Science
AHRC	Atlanta Human Resources Center
AI / AN	American Indian / Alaskan Native
ATSDR	Agency for Toxic Substances and Disease Registry
BRFSS	Behavioral Risk Factor Surveillance System
BSC	Board of Scientific Counselors
CAMICC	CDC / ATSDR Minority Initiatives Coordinating Committee
CDC	Centers for Disease Control and Prevention
COTPER	Coordinating Office Office for Terrorism Preparedness and Emergency Response
CRI	Cities Readiness Initiative
CVD	Cardiovascular Disease
DEO	Division of Emergency Operations
DoD	Department of Defense
DOJ	Department of Justice
DSAT	Division of Select Agents and Toxins
DSLR	Division of State and Local Readiness
DSNS	Divison of Strategic National Stockpile
EC	Enterprise Communications
EIS	Epidemic Intelligence Service
EPA	Environmental Protection Agency
HHS	Health and Human Services
ICS	Incident Command System
IH S	Indian Health Services
IOM	Institute of Medicine
LRN	Laboratory Response Network
MASO	Management and Analysis Services Office
MCH	Maternal and Child Health
MISO	Management Information Sercices Office
NACCHO	National Association of County and City Health Officials
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCHM	National Center for Health Marketing
NCHHSTP	National Center for HIV / AIDS, Viral Hepatitis, STD, and TB Prevention
NCID	National Center for Infectious Diseases
NCIRD	National Center for Immunization and Respiratory Diseases
NCIPC	National Center for Injury Prevention and Control
NCPDCID	National Center for Preparedness, Detection, and Control of Infectious Diseases
NIHB	National Indian Health Board
NIMS	National Incident Management System
NIOSH	National Institute of Occupational Safety and Health
OCOO	Office of the Chief Operating Officer
OD	Office of the Director
OMHD	Office of Minority Health and Health Disparities

OPHPR	Office of Public Health Preparedness and Response
OPM	Office of Personnel Management
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSLS	Office of State and Local Support
OTA	Office of Tribal Affairs
OWCD	Office of Workforce and Career Development
PHEMCE	Public Health Emergency Medical Countermeasures Enterprise
PHEP	Public Health Emergency Preparedness
PHER	Public Health Emergency Response
PIHS	Phoenix Indian Health Service
PHS	Public Health Service
PIMC	Phoenix Indian Medical Center
SLTT	State, Local, Tribal, and Territorial
SME	Subject Matter Experts
SNS	Strategic National Stockpile
SSAG	Stockpile Service Advance Group
TCAC	Tribal Consultation Advisory Committee
TCPW	Tribal Consultation Policy Workgroup
TCE	Trichloroethylene
US	United States
USDA	US Department of Agriculture
VBAC	Vaginal Birth After Caesarean
WHO	World Health Organization

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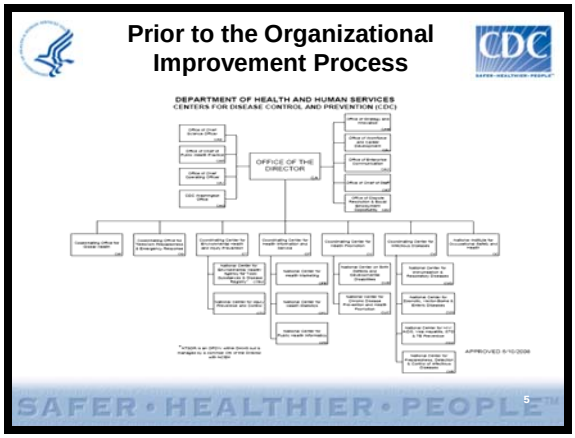
Organizational Improvement Process

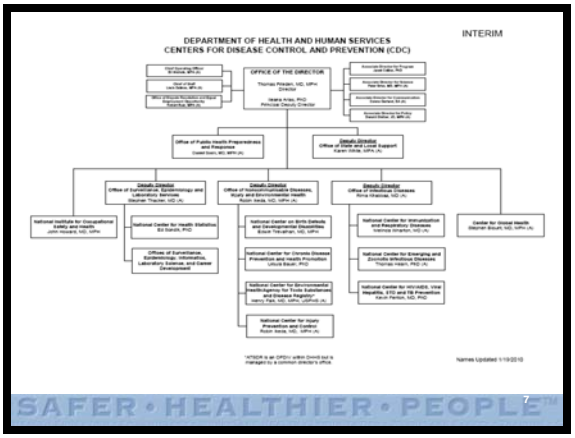
Louis Salinas, BA, MPA, Chief of Staff
Office of the Director
Centers for Disease Control and Prevention

Mr. Salinas thanked TCAC for inviting him to present, and offered greetings from Dr. Frieden. He then reported on CDC's organizational improvement process. Dr. Frieden came on board as CDC's new Director June 29, 2009 and was very eager to initiate some actions to help improve the agency. The guiding principle that Dr. Frieden used for the organizational improvement was that, "All successful organizations continuously assess demands, opportunities and challenges and make appropriate adjustments…to increase effectiveness. Although change is never easy, CDC needs to adapt. Our goal is to solidify CDC's role as a respected leader . . ." His objective was to take CDC back to the premier position he believes CDC should be in not only for the nation, but also for the world. The goals of the organizational improvement effort are to: 1) position CDC to strengthen surveillance, epidemiology, and laboratory sciences; strengthen the agency's ability to support state and local public health; and to strengthen the agency's response to H1N1; and 2) provide public health leadership in global health; health policies, especially health reform; and better address the leading causes of death and disability.

In terms of the organizational objectives, Dr. Frieden wanted to strengthen the response to H1N1 and other public health emergencies; establish systems that better identify and address the leading causes of death and disability; strengthen management and CDC-wide cohesion; place responsibility and accountability in the hands of Center Directors and technical leadership; advance coordination among reinvigorated leadership; rebuild common scientific culture and values for action; and accelerate recruitment of key staff and institution-wide staff strengthening.

As follows are the organizational charts before and after the organizational improvement process:





Dr. Frieden felt that the extra layer of the six Coordinating Centers and the National Institute for Occupational Safety and Health (NIOSH) in the former structure was impeding programs' access to the Director and wanted to change that. Phase I of the organizational improvement process (June 2009 through September 2009) used information from data gathered from an Organizational Issues report, speaking to leaders throughout CDC, CDC employee blogs, and discussions with partners. Phase II (September 2009 through December 2009), the implementation phase, aligned functions and work streams to organizational units. Continuing organizational efforts are to align administrative codes to new organizational units, ensure that office design plans are approved through an internal CDC review or Office of Personnel Management (OPM) / external review, align budgets to new organizational units, et cetera. Administrative, personnel, and budgetary documentation and alignments will continue and are being handled by units throughout CDC, such as the Management and Analysis Services Office (MASO), Management Information Services Office (MISO), and Atlanta Human Resources Center (AHRC), with overall coordination from Office of the Chief Operating Officer (OCOO). All of the senior leadership positions were posted and competed for, and selections for many of the positions have already been made. Several are depending approval at the departmental level and will be announced shortly. Certain activities are now located in the following areas:

- ❑ Office of State and Local Support (Tribal Public Health Liaison Activities)
- ❑ Office of Public Health Preparedness and Response (Strategic National Stockpile) Associate Director for Program (ADP) (Office of Minority Health & Health Disparities)
- ❑ ADP / Office of Surveillance, Epidemiology, and Laboratory Services (Training opportunities: http://www.cdc.gov/omhd/training.htm)

Mr. Salinas highlighted the following quote from White House Executive Order 13175:

> "History has shown that failure to include the voices of tribal officials in formulating policy affecting their communities has all too often led to undesirable and, at times, devastating and tragic results. By contrast, meaningful dialogue between federal officials and tribal officials has greatly improved federal policy toward Indian tribes. Consultation is a critical ingredient of a sound and productive federal-tribal relationship."

In terms of ensuring that there is meaningful dialogue between federal officials and tribal officials, CDC strives to continue discussions to help facilitate continued dialogue to help lead the discussion of programs addressing issues and leveraging resources, which is very important in a climate of having to do more with less. Mr. Salinas pointed out that CDC colleagues would be speaking to tribal leaders throughout the day, as well as the following day during the Consultation Session, with respect to identifying and addressing health issues and will entertain and initiate action to address all of the issues identified to ensure continued collaboration.

Discussion Points

- Mr. Finkbonner raised the issue of input from tribal leadership into the CDC organization improvement process that arose during the TCAC meeting, and was expected to be presented upon the next day during the Consultation Session. With a consultation process, tribal leadership would have been notified and permitted to offer input into the changes prior to its full implementation. The Office of State and Local Support (OSLS), where a majority of the tribal issues will be fielded, some tribal leaders are going to have heartburn that they are being couched in terms of "Local" versus include the term "Tribal" in the name itself. Dr. Bryan and CAPT Snesrud already do a great job in terms of addressing tribal issues, and they and any others in liaison position should help to teach the overall organization how to work with tribes.

- Mr. Salinas responded that Dr. Frieden came to CDC from New York. Mr. Salinas was Dr. Frieden's Program Consultant / Project Officer when he was the Director of the Tuberculosis Control Program in New York in the early 1990s. New York was then suffering from an epidemic of tuberculosis and multi-drug resistant tuberculosis, and had few resources with which to work. Congress reacted and allocated funding to New York to deal with this issue. Federal funds have limitations and working within the bureaucracy it is difficult to spend great deals of money, so he suggested that the best approach would be to divide up the problem into: diagnosis, lab, treatment, and prevention. Dr. Frieden instead insisted that they were going to tackle the problem all at once—move the whole glacier all at once—and he did it. When Dr. Frieden came to CDC, one of the first things he discussed with Mr. Salinas was how to deal with certain issues, including tribal issues. By coincidence, Mr. Salinas ran into CAPT Snesrud in the hallway that day and he explained to her that Dr. Frieden was very interested in this issue and that he would arrange a meeting for her to present information and make some recommendations to Dr. Frieden. CDC considers state, local, and tribal entities to be their partners because the agency cannot do anything without them. Having come to CDC from a local health department, and being very much aware of the quality of technical assistance and how important that is to an organization and to relationships between organizations, Dr. Frieden wanted to do something to make improvements for these relationships. He expressed disappointed in the quality of technical assistance that CDC provides organizations, which varies tremendously. With that in mind, Dr. Frieden wanted to create an office to deal specifically with this issue and to enhance CDC's relationship with its partners. Related to that, he expressed a desired to increase the number of staff actually assigned to organizations because the number of field staff assigned over the years has been limited. Mr. Salinas stressed that they all utilize whatever communication mechanisms available in order to get the message across. With Dr. Frieden, it is about action not "lip service."

- Mr. Franklin responded that Mr. Salinas had offered very encouraging words in speaking so highly of Dr. Frieden and his goals for CDC. He thought the first demonstration of that was how fast Dr. Frieden was moving with the departmental changes. This certainly illustrates that he is a person of action. While Mr. Franklin could see the wisdom of the decision to move tribal issues to OSLS, tribal members have grown tired of being lumped into groupings in which states are receiving top billing. There is no mention in the name of OSLS of tribes at all. The definition of local government seemed to include tribal and territorial governments. When tribes hear the term "local government" they think of something totally different, such as county governments that hate tribes, and city governments that do not want them and fail to recognize that tribes are much more important than they are. Based on the name of the new office, it appeared that CDC was also not recognizing that. Mr. Franklin expressed his hope that CDC would entertain the notion of renaming this the Office of Tribal, State, and Local Support.

- Dr. Bryan indicated that there was some precedent across HHS and within CDC now to use the acronym SLTT for State, Local, Tribal, and Territorial. He thought it was a reasonable message for CDC to entertain from tribal colleagues that the name should include "tribal." Often there is a footnote that state and local includes tribes and territories as well. How

- Mr. Antone relayed concerns about problems with state distribution of funds through cooperative agreements of CDC funds. The way that states have of doing accounting and running their contracts makes tribes look bad. President Obama has recognized government-to-government relationships. Mr. Antone wondered whether any thought had been given to this. In 2005, CDC was contemplating an Indian Office that was separate and distinct that would have a direct line of communication with tribes. He wondered whether there had been any discussions regarding this.

- Mr. Salinas replied that they had not had any discussions about this to his knowledge.

- While Dr. Bryan said he could not confirm whether there had been direct discussions at Dr. Frieden's level at this point, they have put forth written strategies / recommendations for the establishment of a unit directed toward tribal affairs, suggested a name for that unit, Office of Tribal Public Health Support. This in the works and he thought it had been considered as they moved forward in terms of the current plans for OSLS.

- Dr. Williams drew their attention to the document that his office prepared for Joe Henderson and his group as part of the organizational design activities. There was a section that dealt specifically with forming a tribal affairs unit, a potential name, et cetera.

- Mr. Trudell expressed concern that tribes would once again be "lost in the shuffle." He acknowledged the hard work of Dr. Bryan, CAPT Snesrud, and others associated with CDC to bring the problems in Indian Country to the forefront. They have taken people on field trips to various areas to see the issues and problems first hand. Some tribal members have to travel 100 miles to get people to IHS facilities. Some reservations have clinics in their districts, but these are typically understaffed, underfunded, and unable to meet the needs of their districts. The transportation of people from 100 miles out does not lend to a healthy community. His own population of about 4,000 members spread throughout 50 states is highly mobile. Approximately 25% of those members live within the boundaries of the reservation. They provide service to all tribally enrolled people. They have a 638 facility,

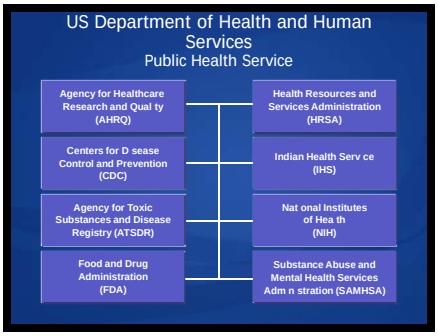
which means they are contract for services. Prior to that and prior to the installation of a bridge across the Missouri River, folks travel 90 miles to Wagner one way, which was their health facility. There is a lack of adequate funding to provide even minimal services. A problem across the countries for all tribes is that if their people are referred our for further assessment and / or treatment of their health problems, is that services are often denied because of a priority system within the IHS. Aberdeen Area participates in TCAC to determine how they can enable more service without people accumulating considerable debt and receiving threatening letters from collection agencies. He thought they were making a lot of progress by having CDC visit reservations to see some of the issues themselves. Aberdeen Area is number one in terms of problems in many health categories. It was not clear to him, with the reorganization, how OSLS would operate. Not seeing "tribes" or "tribal governments" specifically included in the name of the office, he wondered whether they had slipped backwards. President Obama has also visited some reservations and has made a commitment to Indian Country, but it seems that this may be lost in the shuffle of various departments that come under HHS.

- CAPT Snesrud requested that TCAC members save testimony-related comments for the Consultation Session the next day so that they could get through all of the presentations.

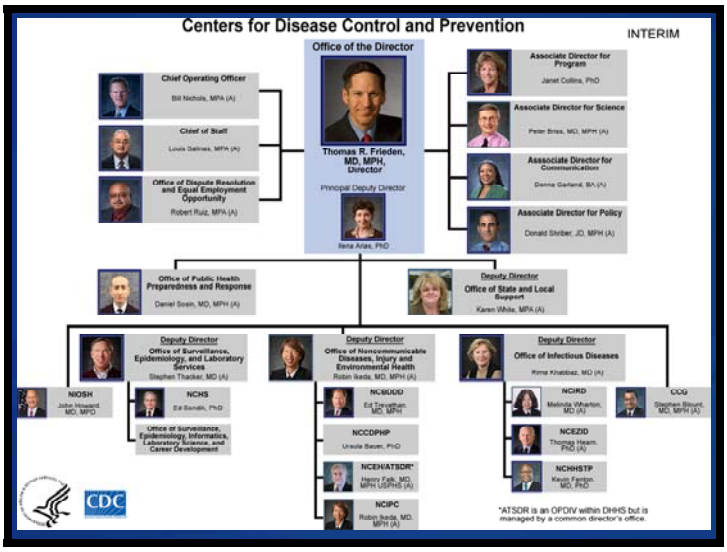
Office of Communications

Donna Garland, BA, Acting Director
Office of Communications
Centers for Disease Control and Prevention

Ms. Garland explained that CDC's mission is to prevent and control disease, injury, and disability. This mission is at the core of what CDC does both domestically and internationally. HHS organization is a Cabinet level organization, and the Public Health Service (PHS) is the uniformed Corps that most people think of as part of HHS. CDC actually contains two boxes within the HHS organizational chart: CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). CDC reports directly to the Secretary of HHS, but CDC also encompasses ATSDR. ATSDR was formed through a Congressional act and was ultimately co-located with CDC in Atlanta, so the Director of CDC serves as the Director of CDC and the Administrator of ATSDR. ATSDR partners most often with the Environmental Protection Agency (EPA), which is why the title of the Director is Administrator, because the Administrator of EPA and of ATSDR are on par with each other. Dr. Frieden holds two official titles within the federal government rubric:



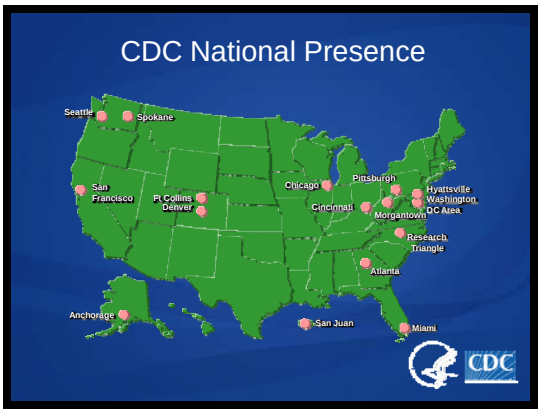
The interim CDC structure is as follows, including photographs of the staff serving in leadership roles:

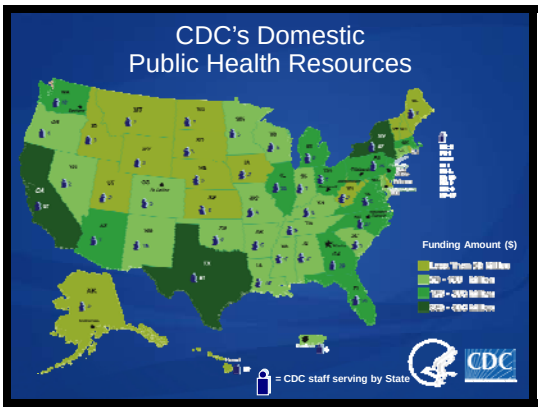


One of the challenges is that many of these leadership staff members are acting; that is, they are either temporary in the position or are awaiting final approval from the Secretary to take on their permanent positions.

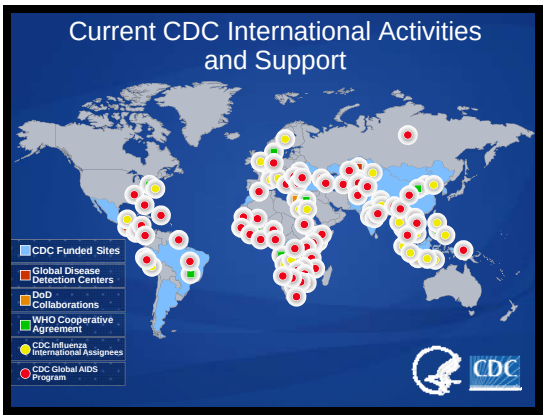
The scope, breadth, and depth of the agency is impressive though it is still not enough to do all of the work that needs to be done. CDC, as the federal agency charged with protecting the health of people in the United States (US), is staffed with world class scientists and world class staff. All of these staff members believe in and carry out the mission of promoting health and quality of life through disease prevention and control and, today especially, being prepared. CDC has a very diverse workforce, yet continues to strive to do better in order to reflect the communities in which the agency works. The make-up of CDC's staff continues to change. More than 1/3 of CDC's employees are members of a racial / ethnic minority groups, women account for over 60% of CDC's workforce, disabled employees account for 5% of the agency's workforce, 25% of CDC's staff is African American, and just under .05% of the agency's staff are American Indian. While the agency stands proud with the diversity it has, they continue to work hard to make the organization as diverse and strong as it can be.

Being centrally located in Georgia, CDC has had and continues to have a profound impact on Atlanta's and Georgia's economy. The agency's total budget was $10.1 billion for fiscal year 2009. CDC ranks among the top 20 employers in Georgia. Based upon an economic impact study, CDC would be 246th on the Fortune 500 list, and would be the 12th largest business in Georgia if budget was revenue. CDC creates 28,000 jobs in Georgia. A KPMG study in 2002 reported that CDC pumped more than $400 million into Georgia's economy in direct purchases, a number that has undoubtedly grown tremendously over the past two years. The majority of CDC employees work out of the Atlanta, Georgia headquarters; however, the agency has a major presence in 16 locations in the US and its territories and provides considerable public health resources as reflected in the following maps:





People are often surprised to find out that CDC funds operations globally throughout the world. CDC has global disease protection centers in which it is developing hubs of operation around the world for early advanced warning of diseases that might affect the US population. International activities and support are depicted in the following map:

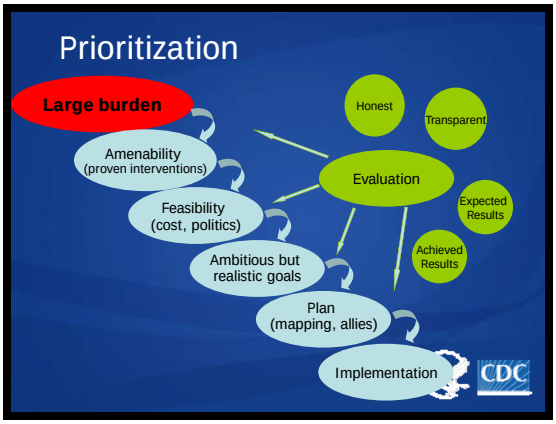


CDC collaborates strongly with the Department of Defense (DoD) globally and in the US. DoD staff are co-located with CDC staff in Atlanta who sit with the Office of Public Health Preparedness and Response (OPHPR), and who work very closely with how CDC is preparing to defend the nation against diseases as well as their mission to defend against other threats. CDC has a significant presence in the World Health Organization's (WHO) office, and share staff back and forth. A number of CDC staff are secunded to WHO. CDC also works throughout the world in HIV / AIDS activities. CDC is responding to the Haiti earthquake disaster. Sadly, CDC still has a staff member who is unaccounted for there who was working in Haiti on HIV / AIDS activities. They had more than 40 locally employed staff who lived and worked in Haiti prior to the earthquake, and have deployed 25 to 30 additional staff members to engage in response work, including epidemiologists, sanitarians, public affairs person, et cetera.

The President Obama clearly recognizes of the role of public health in terms of safety (water, air, food, homes, work); detection and treatment of health problems in all Americans; prevention and control of infectious diseases (immunizations, AIDS); preventable illness and death (smoking, poor nutrition, physical inactivity, safeguard pregnancy); and tracking and monitoring rates of illness and death in communities [From THE WHITE HOUSE, May, 15 2009]. CDC is pleased that public health is on President Obama's agenda. President Obama and his staff were deeply engaged in the pandemic H1N1 response.

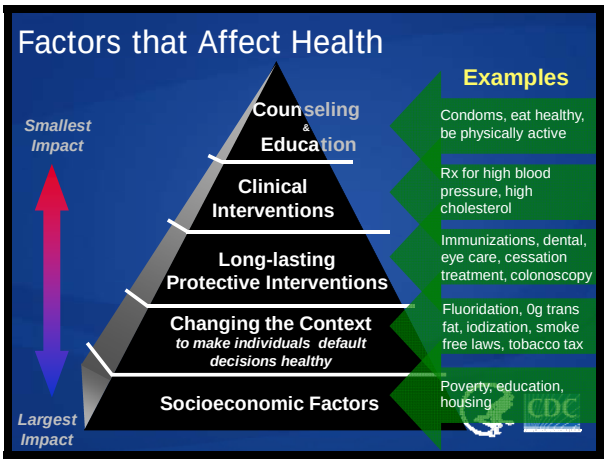
As noted, key CDC strategic directions include strengthening surveillance and epidemiology and the ability to support health departments; and providing provide leadership in health policies, community prevention, and global health. CDC is chartered as a domestic public health agency, but in the real world, diseases do not say, "I can't jump on an airplane and go to the US because CDC does not work there." CDC must also focus on thinking and acting globally to affect the health of all people.

In terms of how Dr. Frieden is helping CDC think differently, among his earliest messages were prioritization of the work that CDC does, as reflected in the following illustration:



While everyone knows that more funds are need, more money is not coming. Therefore, they have to be better about how they focus what they do. The above process chart offers a process by which to think about how to address the burden. The *Community Guide* is a place in which CDC collects and publishes proven interventions. Consideration must also be given to determining the feasibility of the work that the agency does. If something can be prevented and afforded, thought must be focused on ambitious, realistic goals. Dr. Frieden is very ambitious and, as mentioned earlier, wants to move the entire iceberg—not just icebergets or ice cubes. Planning, mapping, and implementing are also crucial. Throughout the entire prioritization / implementation process, there should be an evaluation process that is honest and transparent in terms of assessing expected versus achieved results.

Another way in which Dr. Frieden is helping CDC to think differently about its work is to focus on how much impact CDC efforts have. He uses the following example to illustrate his thoughts about this:



Historically, CDC has spent a lot of time and effort focusing on the top of the pyramid counseling and educating people, giving them guidelines to promulgate. However, as shown in the illustration, those efforts often have the smallest impact because they focus on small effect areas. Dr. Frieden is challenging CDC to focus the efforts toward the bottom of the pyramid that have potentially major impact. The message is not to throw out the items at the top of the pyramid because they are still important, but is instead to be realistic about how much impact such efforts have in the greater sphere of the work.

There are urgent realities. The 21st Century brings with it new challenges, as well as new opportunities. These 21st Century threats begin with the basics of health and include the problems people face everyday such as health disparities, tobacco use, poor nutrition / lack of physical fitness, overweight and obesity, drug and excessive alcohol use, poor mental health, chronic diseases (e.g., cardiovascular disease, cancer, diabetes, lung disease, kidney disease, and other chronic conditions), non-intentional and intentional injuries, premature birth, birth defects, disabilities, and unsafe environments. Many of these threats are preventable, but are still increasing in communities across the US. More and more people are not able to enjoy the best possible quality of health as a result. Dr. Frieden has challenged them to change the mindset that some ailments are simply part of living, and instead think about a different reality in which hypertension, for example, is not a part of the way we are supposed to live and that there is a choice to do things differently. CDC has a major leadership role to play in combating these threats by supporting the research and programs necessary to ensure that people and CDC's partners have access to the best possible health protection information and tools they need; and to make decisions about health. Business as usual is not enough. They must do more and do it faster, smarter, and better in order to make an impact. In the midst of thinking about chronic conditions and illnesses that can be prevented, they must also be prepared, able, and willing to respond to critical urgent matters of the day. CDC has engaged in numerous exercises and real response efforts in order to respond to the world's challenges. Ms. Garland said that she is proud to work at a CDC that is willing and able to stand up and serve when emergencies occur, in addition to addressing day-to-day challenges.

Discussion Points

- Mr. Antone requested information about CDC's social determinants of health efforts.

- Ms. Garland responded that she did not know a lot about it, given that she had be immersed in the organization improvement efforts throughout the last few months. There is a very strong work group that is addressing social determinants of health. They have taken an academic approach to begin with, but are working to figure out how social determinants of health can proliferate throughout the organization. She stressed that just because she was not aware of activities did not mean they were not in progress.

- Mr. Antone wondered whether due to the reorganization of CDC, addressing social determinants of health had come to a halt.

- Ms. Garland responded that she would not say that it had come to a halt, given that there are numerous program folks who are still working on this, but do not know yet exactly where they fit in the organization.

- CAPT Snesrud asked Mr. Antone whether he was referring to the meeting the National Center for HIV / AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) hosted in December 2009.

- Mr. Antone responded that Dr. Fenton was going to sort out all of the suggestions that were generated during that meeting and perhaps include them as a requirement in grant applications, and then monitor this. The theme of that meeting was important in terms of the Native American community and raise the standard of living. Women, being the carriers of the unborn, need to be healthy because that contributes to everything a person is. He thought this was an important concept to embrace.

- CAPT Snesrud indicated that Dr. Fenton and Dr. Dean from NCHHSTP would be in attendance at the Tribal Consultation meeting the next day, and she planned to make sure that Mr. Antone was afforded the opportunity to have some dialogue with them.

- In terms of communication, Mr. Antone requested that Ms. Garland shed some light on how American Indian / Native Alaskan issues (AI / AN) issues that come forth are transmitted to Dr. Frieden.

- Ms. Garland replied that in terms of CDC's communications work CDC and the organizational improvement effort, they have been challenged over the last few months with merging two prior communication groups into a single Office of Communication and making that smaller: Enterprise Communications (EC) and the National Center for Health Marketing (NCHM). One component of the communication effort under Dr. Frieden is his deliberate effort at tactically sending messages to tribal nations and others. Some of the work included in her work plans is from the last TCAC meeting regarding the implementation of specific communications activities with tribes. She also has e-communications as part of the new office, so she is interested in determining how that can help them better connect with tribes to have a two-way process.

- Mr. Antone also wondered specifically how information from OSLS, TCAC recommendations for example, would be submitted to Dr. Frieden.

- Dr. Bryan responded that this is a question in front of them currently in terms of logistics and process as they plan through the transition with Karen White, Kristin Brusuelas, and others engaged in a leadership role in terms of channeling messages to the Office of the Director (OD). He suggested asking the question again of Karen White when she presented later in the day.

- CAPT Snesrud pointed out that Ms. Garland's office had been and would continue to be a critical link in how they connect the breadth and depth of CDC in a format that tribal leaders could readily access.

Overview and Importance of CDC Tribal Consultation Policy

CAPT Mike Snesrud, Senior Tribal Liaison for Policy Evaluation
Centers for Disease Control and Prevention (CDC) /
Agency for Toxic Substances and Disease Registry (ATSDR)

In light of where they are currently, CAPT Snesrud said she thought it was important to take a look back historically at the journey that CDC had taken, in particular, in the development of the CDC Tribal Consultation Policy which has been the driving force that has enabled a lot of the synergy that has been going on throughout the agency to be responsive to public health issues affecting AI/ANs. . CDC's Tribal Consultation Policy Initiative reflects CDC's commitment to take its place in assuming a role in implementation of the federal trust responsibility. The statement that CDC made early on was that it's policy would be evolving, dynamic, and able to be changed as the dialogue and consultations with Tribes ocurr. As HHS is evaluating their consultation process and tribes are sharing their opinions, CDC is critically assessing this in relation to CDC's policy.

The Tribal Consultation Policy Initiative occurred from 1999 to 2005. A CDC Tribal Consultation Policy Workgroup (TCPW) was re-established in 1999 that was comprised of natives and non-natives who were very interested in and committed to furthering the work that the agency as a whole was doing with Indian Country. In March 2000 and February 2001, under Dr. William's leadership, CDC hosted the first tribal meetings. Some of the dialogue and testimony from the transcripts then continued to be reflected in current dialogue and testimony, so while we have come a long way, Tribes and CDC need to consider what can be added to current interactions based on the work that was done then. When CDC was directed by HHS to develop a plan and an agency-specific tribal consultation policy, the TCWG developed a comprehensive plan to obtain input from tribal leaders on tribal public health needs and CDC's proposed approach to tribal consultation. The plan was published with HHS in January 2001.

The Tribal Consultation Initiative included 12 CDC national and regional tribal consultation sessions hosted by area Tribal health boards held during the Summer and Fall of 2002. The sessions facilitated dialogue and garnered input from tribal leaders and AI/AN stakeholders across the country. During 2003 there were also HHS regional tribal consultation sessions, 9 out of 10 which CDC Senior Tribal Liaisions and other leadership staff participated in. The CDC Tribal Consultation Plan was presented at the National Indian Health Board (NIHB) Consumers

Conference in 2003. CDC continued to participate in HHS regional consultation sessions in 2004 to consult and obtain additional tribal recommendations. The draft policy was presented at the NIHB Consumers Conference in 2004. A revised draft of the Tribal Consultation Policy was published for tribal comment during early 2005. During July through August 2005, based on tribal recommendations, CDC and ATSDR Consultation Policies were combined into one policy. ATSDR had originally developed their consultation policy in 1994. Released in October 2005, CDC / ATSDR became the first of 11 HHS operating divisions to establish a tribal consultation policy in compliance with the revised HHS Tribal Consultation Policy released in January 2005.

The Federal Trust Relationship is unique and is expressed through recognizing and honoring of tribal sovereignty, commitment to government-to-government relationships, upholding and supporting of the federal trust responsibility, and commitment and implementation of tribal consultation. The purpose of the CDC Tribal Consultation Policy is that it establishes agency policy on consultation with AI / AN governments and elected leaders; provides guidance to agency staff on working effectively with AI / AN customers; enhances tribal access to agency programs; complies with and supports HHS policy; and is dynamic, responsive to change, and modifiable.

Procedural guidance offers information pertaining to understanding about when and with whom to consult; engaging tribal representatives as meeting co-chairs and following their guidance on protocol; involving state health department representatives; documenting consultation activities accurately and completely; and providing timely feedback to tribal consultation participants and the communities they represent. Activities that warrant consultation include the following:

- ❑ Formulation of new program announcements primarily intended to benefit AI / AN populations
- ❑ Notices of proposed rule making that have tribal implications
- ❑ Establishment of new public health programs targeting AI / AN
- ❑ Development of policies or guidelines that have tribal implications or will primarily or substantially affect AI / AN populations
- ❑ EPI-AID deployments involving AI reservations or trust lands, AN villages, or urban AI / AN populations
- ❑ Research proposals involving AI / AN persons or communities
- ❑ Development of training and educational opportunities for AI / AN health professionals, or future health professionals
- ❑ Negotiations with state and local health officials on matters affecting AI / AN populations within, or adjacent to, their public health jurisdictions

Key activities include CDC biannual tribal consultation sessions; Tribal Consultation Advisory Committee (TCAC); HHS national and regional tribal consultation sessions; and agency budget formulation and resource allocations for tribal programs.

The purpose of TCAC is to provide a complementary venue wherein tribal representatives and agency staff will exchange information about public health issues in Indian Country, identify urgent public health needs in AI / AN communities, and discuss collaborative approaches to addressing these issues and needs. TCAC is a FACA-exempt advisory committee to the CDC / ATSDR Director. TCAC supports, and not supplants, any other government-to-government consultation activities; assists in the planning and coordination of biannual tribal consultation sessions; provides an established, recurring venue wherein tribal leaders will advise the agency regarding the government-to-government consultation process; and helps to ensure that activities or policies that impact Indian country are brought to the attention of all tribal leaders.

Responsibilities for CDC through the proposed Office of State and Local Support (OSLS) are to monitor and ensure agency-wide adherence to CDC and HHS tribal consultation policies; and serve as the administrative base for two Senior Tribal Liaisons, "OD / CDC staff designated by the CDC Director who are knowledgeable about the agency's programs and budgets, have ready access to senior program leadership, and are empowered to speak on behalf of the agency for AI/AN programs, services, issues, and concerns." OSLS reporting and inventory functions include management of agency assets devoted to AI / AN; collaboration across national centers and offices in regard to tribal programs / services; monitoring agency performance measures; reviewing and clearing AI / AN-related documents and publications; and CDC response to departmental information requests and required annual reports.

OMHD / OCPHP / OD points of contact include the following:

- CAPT Mike Snesrud, RN, Senior Tribal Liaison for Policy and Evaluation (pws8@cdc.gov, 404-498-2343)

- CAPT Ralph T. Bryan, MD, Senior Tribal Liaison for Science and Public Health (rrb2@cdc.gov, 505-248-4226)

OTA / NCEH / ATSDR points of contact include:

- Annabelle Allison, Tribal Liaison, Office of Tribal Affairs, (hhd4@cdc.gov, 770-488-3991)

CDC / ATSDR Minority Initiatives Coordinating Committee (CAMICC) representatives' responsibilities include monitoring Center / Office (C/O) compliance with the procedures outlined in the Tribal Consultation Policy; advising C/O directors regarding tribal consultation procedures; maintaining timely information flow to and from OD / CDC on AI / AN issues; participating in TCAC meetings on behalf of their respective CC / CO; and supporting agency-wide consultation efforts; assist OSLS, the Senior Tribal Liaisons and NCEH / ATSDR OTA in the coordination of activities that target AI / AN tribes, communities, and organizations. CAMICC responsibilities are to ensure that Center / Office leadership is well-informed about AI / AN health issues; and provide the information needed to compile CDC's Annual Report to HHS on Tribal Consultation activities and budget allocations. Tribal Consultation Policy and Center responsibilities include consultation at the center level to promote the principle that each center bears responsibility for addressing AI / AN public health needs within the context of their respective missions; and effective implementation of these components to ensure consistency across the agency and help to enhance collaboration among centers / offices around tribal issues.

Current CDC AI / AN programs include tribal grants and cooperative agreements; CDC-funded state and academic programs; technical assistance and outbreak investigations; community outreach / health assessment; training and publications; direct assistance, field assignees; and designated staff. With regard to intra-agency consistency and sustainability, the CDC TCP provides CDC staff and leadership with uniform guidance for working effectively with its tribal partners and constituents. The policy identifies when CDC programs should involve tribal leaders, outlines specific responsibilities for agency components regarding program activities, and also formally defines the roles of leadership positions within the CDC dedicated exclusively to guiding CDC operations in, and relationships with, AI / AN communities (Senior Tribal Liaisons). A strong consultation policy is the foundation for effective government-to-government relationships. The procedural guidance provided by this policy provides is helping to ensure that more tribes and tribal organizations benefit from CDC expertise and resources by eliminating barriers and enhancing tribal access to CDC programs.

In order to enhance tribal access to CDC and ATSDR programs to benchmark steps toward effective tribal consultation, annual performance measurement will include assessment of resources allocated to serve AI / ANs; and inventory of new programs and policies affecting AI / AN communities. Enhanced tribal access to CDC programs and resources creates impact. CDC's commitment to meaningful consultation with AI / AN tribes and increased awareness among tribal stakeholders of CDC as a partner has helped to bring more CDC resources to Indian country. Guidance has begun to enhance both intra- and extra-agency operations to improve CDC tribal relationships and strengthen the public health impact of CDC programs in Indian Country. Internal operations and communication related to AI / AN health programs have been established and have become more efficient and effective. The Tribal Consultation Policy, as official policy, is helping to ensure sustained application of these uniform guidelines beyond the tenure of current staff / leadership. The following table reflects the type and number of tribal cooperative agreements from 2004 to 2009:

Tribal Cooperative Agreements

Categories of Awardees	FY 2004 (48 / 58)	FY 2005 (51 / 66)	FY 2006 (50 / 68)	FY 2007 (48 / 68)	FY 2008 (51/ 76)	FY 2009 (56/78)
Tribal Governments	14	21	20	20	25	33
Health Boards	8	9	8	7	6	12
AN Corporations	6	7	9	9	6	19
Urban Programs	3	6	6	6	5	6
Tribal Orgs	11	8	7	6	9	8
Total Dollars Awarded	$25,694,984	$22,523.405	$22,029,344	$21,948,174	$22,839,514	$23,854,212

Knowledge to Action Science Clips

John Iskander MD MPH
Office of the Associate Director for Science
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry

Dr. Iskander reported that the vision of the Office of the Associate Director for Science (ADS) is that "Excellent public health science is available and regularly used to solve important real world problems" and that its mission is to "Ensure the quality and integrity of CDC science and encourage the use of the best science to solve public health problems." The Acting Associate Director for Science is CAPT Peter Briss and the Deputy Associate Director for Science is Tanja Popovic.

One of the collaborations that the ADS office has been working on with the CDC Library and a variety of subject matter experts within CDC is a project called Science Clips, a weekly public health literature compilation service intended to serve as "scientific situational awareness." Science Clips have an emphasis on applied public health and prevention science that has the capacity to improve health now. Dr. Bryan came up with a very innovative idea, which was to develop a supplement issue in conjunction with the Consultation Session focusing on AI / AN public health issues, with his leadership and a variety of other subject matter experts and the outstanding work of the CDC Library—one of the hidden treasures of the agency:

- Subject matter experts representing multiple CDC centers including NCCDPHP, National Center for Immunization and Respiratory Diseases (NCIRD), National Center for Preparedness, Detection, and Control of Infectious Diseases (NCPDCID), and Office of Workforce and Career Development (OWCD) include Ralph Bryan, Lemyra DeBruyn, Nancy Kuchar, Dave Espey, Tom Hennessy, Howie Goldberg, Amy Groom, and Myra Tucker.

- CDC library staff include: Jocelyn Rankin, Director; Gail Bang, Team Lead; Rebecca Satterthwaite; and Deidre Thomas.

This is available to everyone who is on the All CDC distribution list, and an electronic version was provided to TCAC members the previous day. In addition, hard copy versions were expected to be provided during the Consultation Session the next day. Dr. Iskander said he was struck by the fact that these encompass the breadth of public health, including diabetes, chronic disease prevention, injury prevention, violence prevention, H1N1, broader infectious disease issues, et cetera. They are truly emblematic of the challenges and prevention opportunities currently facing the community. Whenever possible, there is a link to the publications. They will use HAN for distribution and PubMed to allow as much access as possible.

Future Directions for Science Clips include internet posting, access and alerting for SLTT staff more broadly, and additional supplements and enhanced editorial content. Feedback may be sent to scienceclips@cdc.gov or the CDC Public Health Library and Information Center may be contacted via telephone at (404) 639-1717.

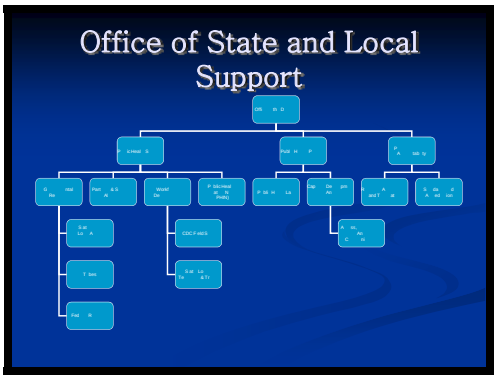
Office of State and Local Support

Karen White, Acting Deputy Director
Office of State and Local Support
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry

Ms. White indicated that the mission statement of the Office of State and Local Support (OSLS) is, "To achieve a healthier United States through a public health system comprising the Centers for Disease Control / Agency for Toxic Substances and Disease Registry, state, territorial, and local health departments and tribal governments. Their vision statement is, "To improve the health of America." This is a system to improve the health of America that includes CDC and state, county, local, tribal, and territorial entities. This is about America as a country, as well as a country of people. The organizational improvement process focused on functions versus form and structure. Functions of this office are to:

- Promote shared leadership of public health policy and practice with public health agencies through increased collaboration and communication
- Develop and oversee a cross-agency process of performance and accountability that monitors the achievements and advance of the national public health system
- Provide guidance, strategic direction, and oversight for investment of CDC resources and assets in public health agencies
- Expand and develop the capacity at public health agencies in support of public health practice
- Support the development and implementation of public health information technology and management that assures the rapid collection, analysis and dissemination of data to assist in establishing program goals, objectives, priorities
- Provide guidance, strategic direction and support for the recruitment, development, and management of the nation's public health workforce

The OSLS organizational structure is as follows:



OSLS is horizontal in scope, strategic in action, and supportive in purpose. It is not vertical, tactical, or punitive. It is crosscutting and is not engaged in any single program or responsible for any categorical program or single action of work. OSLS is looking at systems, practice, performance, and accountability as a whole of public help. They engage the vertical side of things in a way to achieve a good horizontal approach. They are the nexus of where the vertical and horizontal meet. The value of this office pertains to how it exploits and expands its point at the nexus and leveraging. Bringing tribal health concerns and tribal partners and relationships to the forefront is a strategic issue versus just dictating this. They can demand that tribes be included in grants, but that will not make any difference. These issues and discussions must be strategically placed in order for people to think about how they work with tribes, and how they engage the help of native people into the way they think about public health and chronic disease. This office is also meant to be supportive in purpose. That is in the name, and will not change, and is in the intent of what they do.

With regard to next steps, the tribes are a separate unit within the Branch of Government Relations. This is a blessing and a curse. The blessing is that it is there and it stands alone and stands out. Everybody will have to work together on this. The challenge is that there is nothing there other than Dr. Bryan and CAPT Snesrud. While they have strong backs, they cannot carry this all on their own. Plus they have a lot of years to make up for at CDC in terms of the way that they have managed this and organized it. She gave Dr. Bryan and CAPT Snesrud a week following this meeting to "hit the ground running" in terms of establishing this office and this team. Throughout February, they planned to bring in the bigger picture and issues. She expected Dr. Bryan and CAPT Snesrud to reach out to TCAC members with regard to the way they should be thinking about this. Beginning March 1, 2010 they will strategically think about how to set up this team in OSLS and how the team relates to other teams in Government Relations and across the other areas of OSLS. CAPT Snesrud told her the previous day that it would feel good to be part of a larger team and to have the support of others around her who want to do the right thing to more fully engage Tribes and work to make this happened in multiple ways. Ms. White expressed her hope that by the next TCAC meeting in the summer, they would really be able to see a difference in the way that this office is working with tribes and the way that this team is structured to work and relate to tribes. As she said earlier, she saw this as a relay to take what has been established so far within the Office of Minority Health and Health Disparities (OMHD), pick up the baton and take it the next part of the journey.

Ms. White shared her contact information, which is 404-639-7804 and kew1@cdc.gov. She stressed that she sincerely wanted people to feel free to call her or leave her a message. In conclusion, she thanked TCAC members for the privilege to talk with them. In her 25 years with CDC, while she has worked with individual tribal members and individual tribes, this is the first time that she has been able to speak with a larger group of tribal members.

Discussion Points

- Mr. Antone requested that Ms. White elaborate on funding through states and that this may not be working very well.

- Ms. White acknowledged that there have been times when states have not funded tribes at a level that they should have to resolve a challenge or a problem. States have been CDC's

primary portal for distributing funding, but they do not focus well or spend some of their funds well at the local level regardless of whether it is a large city, small city, or county. They assess whether states are posing barriers to getting funding out, and how the funds that states do have can be leveraged. They have conducted some assessments in states where the senior management officials are, though they have not been able to change a lot of what Congress intends for CDC, but they have been able to reflect better on the way states work with the funds that CDC provides to them and to try to influence and inform the expansion of states' thinking. Everyone in public health has worked in public health a thousand years it seems. There is almost never a new person in public health. The challenge is to help these individuals think differently such that they give thought to other means of distributing funding (e.g., providing funding in a separate stream, engaging tribes directly, working directly with the county instead of flatly giving everybody $10,000). Some states have been very responsive to that and have admitted that they did not previously consider thinking different. This also has to be changed at CDC in terms of getting folks to think more deliberately about the way they allocate funding.

- Mr. Antone expressed his hope that tribes would not be imbedded with locals in terms of disseminating funds and information.

- Ms. White replied that that intention of OSLS is to work with all four units as equals: states, territories, tribes, and locals. The state does not have any more dominance in terms of decisions. That mindset is part of how they are working with CDC. When they talk to CDC about some of the decisions being made and point out some of the issues, such as why certain mechanisms are being used for funding, or why information is being disseminated in a particular way through states versus directly to tribes, locals, and territories. Often this is reflexive and people do not know why things are done in a certain manner. Dr. Bryan and CAPT Snesrud have been great about providing contact information, et cetera. That is an intended change in the way that CDC will work.

- Mr. Finkbonner said he was glad to hear that they were taking into consideration the way that resource utilization is being used at the state and local levels. He suggested assessing resources in general, not just funding. H1N1 is just one of the resources that CDC allocates to the states, and is a prime example of how public health works once resources leave CDC and is given to the states to provide to tribes. Some states are very good at this, while others are not. Some states have the best intentions, but the resources do not always make it to the places where they are most needed in an efficient manner. He offered to provided specific examples in order to contribute to the information needed by OSLS.

- Ms. White said it would be helpful to receive further information. She stressed that she was not CDC bashing or headquarters bashing. There is a challenge in recognizing that not all states do the right thing. People at CDC always begin with the right intention to do the right thing, and it takes a little while before they realize that this does not always translate down. This is not out of malice or neglect, but simply out of habit a lot of times. When CDC has pointed those issues out and has been able to provide evidence, the states typically realize that this is wrong and they are able to respond about the way they should have done something or explain why they did something the way they did. Sometimes the policy or resource distribution is not changed, but if it is explained, people are much more comfortable with the way that it went and then can figure out how to change it in the future.

- With regard to data sharing, Ms. Begay noted that CDC provides funding to the state and IHS. For several years tribes have been requesting access to data. This is another area she hoped that OSLS could assist tribes in gaining access to data that would help them improve their emergency preparedness, planning, implementation, and evaluation of public health activities in Indian Country. Data is a crucial area for which tribes have been advocating.

- Ms. White said that while she could not make any commitments from the state perspective in terms of what data they collect, what they share, and how they share it with CDC. However, as part of information technology and management, OSLS is interested in engaging the tribes and others with respect to improving data collection / access. Data is at the heart of everything CDC does. If everybody does not have the right data or access to the right data, nothing can happen. Everyone must realize that data is at the heart of everything they do and share as much of it and be as transparent with it as possible. As they discuss the work that will occur in the next several months with regard to the tribes and developing strategies, data should be at the top of the list.

- Ms. Begay suggested that since CDC gives funding to the states, it should be a requirement of the contractual agreement and part of OSLS's oversight to ensure that states are required to work closely with tribes to provide them with data.

- Ms. White replied that this office will be able to do this. Because they do not work vertically, they will not be able to write the grants or cooperative agreements, but they can influence what goes into these to ensure that they include language directing states to work with tribes and to share data with them. They can also recommend working more directly with tribes on this issue. In a meeting she attended earlier in the morning, the question was raised regarding how CDC could ensure that this occurs, and she suggested including it in cooperative agreements.

- Dr. Kraus stressed that tweaking the name of this new office to include the word "Tribe" or "Tribal" is essential. There is not a level of understanding that tribes actually exist and that tribes should be on a peer level. This is not on a lot of public health people's horizons, even with states that directly surround major tribes or series of tribes. She has found this to be true even with some CDC staff. If someone has not started out in a tribal area, none of their other experiences will prepare them for the multitude of issues. It is very educational to have the word "Tribal" so that people will think about it. The people who approach the office need to know that tribes are a major partner.

- Ms. White agreed and said that this was a reflexive response in terms of the office. They do have to think about this. As they have worked through some issues over the last several months that have arisen with respect to this office is that this is the dress rehearsal. They are trying to figure out what they can do, what they have done right, what they have done wrong, and then make corrections to that. Clearly, the name is going to require further discussion and they will address this issue. They also plan to do some work out of this office with regard to changing culture and changing thinking, which reflects this point, in terms of making sure that tribes are visible not only in the name of the office, but also in the work and the way CDC considers work. Culture change is an effort that will come out of this office in terms of what it means for this office to give state, local, tribal, and territorial support. This is about listening, incorporating what is heard into the way the work is done,

and demonstrating that through the product. They have to change the way people think about this. This is not something they can edict. Instead they want to acknowledge that the culture at CDC in terms of working with different partners has to improve. This has to similarly improve on the outside. This is not just CDC's problem. Part of the reason that this office was developed was because the relationship between CDC and states, locals, tribes, territories, and other partners and strategic alliances were broken. CDC acknowledged this right up front. Dr. Frieden being a local health officer was the first one to say that. However, there is no relationship that is broken on one side. It has to be broken on both sides. Without these conversations up front, everything else is lost. She requested that they engage with Dr. Bryan and CAPT Snesrud to share more ideas about how to make this better at CDC and in the states that surround the tribes and have not been responsive.

- Mr. Valdo emphasized that it would mean a lot to tribes to be included in the office name. It is in the mission, and while he appreciated that, tribes need to be elevated if it will not ruffle any feathers.

- Ms. White replied that it would cause no heartache for anyone, because several people at CDC have pointed this out. It should not ruffle any feathers, but if it does, who cares? That is the best way of getting some things done. She assured them that she would take this back as an issue.

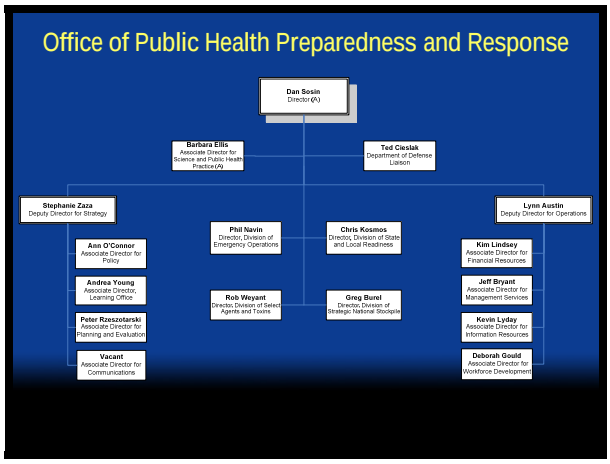
- Mr. Gilbert pointed out that all tribes do not fit the same mold from state to state or reservation to reservation. This is definitely true for Alaska where they have to deal with state, county, and borough governments. He extended an invitation to Ms. White to visit Alaska in order to better understand how their processes work in terms of tribal health programs' and tribal governments' relations to Alaska local governments.

- Ms. White thanked Mr. Gilbert and said she would really like to do that for a couple of reasons, one of which is that it would be great to work closer and to get to know the tribes from where they work, and she has been dying to travel to Alaska to talk about public health but nobody has asked her. As the federal government, they have to be invited, and she considered this an invitation and will look into it.

Office of Public Health Preparedness and Response

Lynn Austin, PhD
Deputy Director for Operations
Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention

Dr. Austin thanked TCAC for offering her the opportunity to speak with them. She is fairly new to OPHPR, which was formerly known as the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER). Little changed about the organizational structure, though there were some minor changes. The organizational structure is reflected in the following chart:



OPHPR has four major divisions, though COTPER had five. One of COTPER's divisions was the Division of Business Services, which they did not really consider a programmatic division, so that has been moved into an office within the Office of the Director. OPHPR is operating currently with two Deputy Directors, Dr. Austin and Dr. Stephanie Zaza, who is the Deputy Director for Strategy. Dr. Austin reviewed each box in the organizational chart. She explained that the offices in the wings support the four major divisions in the middle: Division of Emergency Operations (DEO), Division of State and Local Readiness (DSLR), Division of Select Agents and Toxins (DSAT), and Division of Strategic National Stockpile (DSNS).

The vision remains largely the same, "OPHPR helps the nation prepare for and respond to urgent public health threats by providing strategic direction, coordination, and support for all of CDC's terrorism preparedness and emergency response activities." OPHPR's mission is, "We safeguard health and save lives by providing a flexible and robust platform for public health emergency response." Ever since Dr. Austin has been there, they have been in a public health response, which is unheard of and unprecedented in their history since they began as COTPER. H1N1 began within two weeks after she arrived at OPHPR and is not over, and now they are in the throes of the Haiti response. There is an extraordinary amount of work underway. She has been at CDC for over 20 years and 33 years with the government, and she has never seen an organization so dedicated and work so hard and such long hours.

OPHPR focuses on an all-hazards approach to maximize available resources, so terrorism and emergency response dollars are to focus on four primary areas: biological and chemical attacks; nuclear / radiological events; trauma / explosion injury-related types of events; and natural / environmental events such as in Haiti. OPHPR has the capability through the public health system of working with communities and individuals to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities. OPHPR has a Joint Information Center that is really a central part of distributing information and response to a terrorist or public health emergency event, and is trying to unite communities to be protected from infectious, occupational, environmental, and terrorist threats. That includes Tribal Nations.

OPHPR's focus is to provide a strategic direction on preparedness to CDC, as well as training and education. There were bits and pieces being done, but this was not done in a very cohesive, organized manner. Through an appropriated line item, OPHPR now has funds to allocate across CDC. There is a large terrorism preparedness budget, but OPHPR itself keeps only about 10% for in-house operations. Most of the rest of the funds are allocated through public health partnership grants, the stockpile, and across CDC. The subject matter expertise for the four primary areas of focus (e.g., biological / chemical; nuclear / radiological; trauma / explosion; and natural / environmental) is outside of OPHPR in the National Center for Environmental Health (NCEH) or National Center for Infectious Diseases (NCID). OPHPR is the facilitator as well as coordinator of the funding and projects and priorities that go out to those organizations. OPHPR CDC is committed to publicly reporting the progress that states and other awardees have made in public health preparedness and to develop appropriate, specific, measurable, and validated performance measures. OPHPR is committed to presenting an increasingly clear picture of public health preparedness in the US. The first report was published in February 2008 on state preparedness activities funded through the Public Health Emergency Preparedness Cooperative Agreement. The second report was published in January 2009 on Terrorism Preparedness and Emergency Response funded activities across CDC, and the third report is scheduled to be published in 2010 on progress in state preparedness.

OPHPR is very focused on ensuring that populations are well-represented. To that end, they have a Board of Scientific Counselors (BSC) that gives advice and direction to OPHPR and sets part of the strategic focus and direction for OPHPR's programs and priorities. Dr. Austin reported that BSC member Bonnie Hillsberg has been representing American Indian / Alaska Native tribes. Dr. Hillsberg is a Senior Program Manager at the National Indian Health Board (NIHB). NIHB advocates on behalf of all Tribal Governments and American Indians / Alaskan Natives in their efforts to provide quality health care. Her role is to increase public health capacity in all of Indian Country, which includes injury prevention, diabetes, obesity, cancer, chronic disease, elder care, HIV / AIDS, tobacco, substance abuse, suicide prevention and other health issues that affect Native American and Alaskan Native communities.

With respect to OPHPR's operational focus, over $700 million is set aside to fund cooperative agreements for state and local preparedness efforts. These cooperative agreements include language requiring state and local entities to work with AI / AN. The funding also supports a large amount (over $500 million) in the Strategic National Stockpile (SNS) of critical medical assets, which is to protect state and local communities. The federal government supports and coordinates having the stockpile, but its sole purpose is to protect the citizens of this country and other assets when called upon to do so. OPHPR also manages CDC's emergency response operations through the CDC Emergency Operations Center; and manages the regulation of the possession, use, and transfer of select agents to protect public health and safety. These funds are managed by OPHPR DSLR, which provides guidance and funds (~$688.9 million in FY09) to 62 state, local, and territorial public health departments to strengthen preparedness, including for pandemic influenza. DSLR also provides technical assistance and consultation through Project Officers and CDC Subject Matter Experts (SMEs); and develops performance metrics and gathers performance data on exercises and real events through public health department reporting.

DSLR has developed and implemented a Public Health Emergency Preparedness (PHEP) evaluation framework and related capacity and capability performance measures. Currently, PHEP awardees are collecting and reporting data on seven performance measures in laboratory preparedness, incident management, and crisis and emergency risk communications. Work is underway to develop performance measures in other areas. All states have public health emergency preparedness and pandemic influenza response plans in place. All states have staff to evaluate urgent disease reports 24/7/365. More than 160 Laboratory Response Network (LRN) laboratories can test for biological agents, with nearly 90% of the US population living within 100 miles of an LRN lab. All states trained staff in their roles and responsibilities during an emergency using the Incident Command System (ICS). All states have a crisis and emergency risk communication plan.

The Strategic National Stockpile is managed by OPHPR's DSNS, which manages and maintains the national repository of critical medical assets including antibiotics, antiviral drugs, antitoxins, other life-support medications, and supplies. DSNS also procures, stores, and delivers these assets to the site of a public health emergency and can deploy a Stockpile Service Advance Group (SSAG) to assist state and local officials during a public health emergency. In addition, DSNS provides technical assistance to state and local public health departments to move medical assets from warehouses to points of dispensing. All states have plans in place for receiving and distributing Strategic National Stockpile assets and are exercising those plans. The supply of smallpox vaccine has increased from 15.4 million doses available in 2001, to more than 300 million full doses currently—enough to vaccinate every American, if necessary. Treatment countermeasures stockpiled in regard to pandemic influenza (e.g., antiviral drugs, respirators, and surgical masks) continue to increase. The CHEMPACK Program forward places life-saving medical assets in states for use in the event of a chemical incident. The Cities Readiness Initiative (CRI) helps major US metropolitan areas increase their capacity to dispense antibiotics within 48 hours of a public health emergency

CDC's Emergency Operations Center is managed by OPHPR's DEO, which functions as CDC's command center for coordinating emergency responses to domestic and international public health threats. The center is staffed 24/7/365 to provide worldwide situational awareness and coordinate CDC's preparedness, assessment, response, recovery, and evaluation for public health emergencies. The EOC serves as point of contact for state agencies reporting potential public health threats to CDC. The EOC increased its level of response 44 times to respond to public health emergencies between September 2001 and April 2009 and a couple of times since then. More than 1,300 people were deployed during the recent pandemic H1N1 influenza virus outbreak. In addition, the EOC conducted agency-wide exercises to test response plans for hurricanes, detonation of radiological dispersal devices, and an outbreak of pandemic influenza; and implemented the National Incident Management System (NIMS) in 2005 to better coordinate and manage emergency responses by all federal, state, and local agencies.

The following is snapshot of the kinds of responses for which the EOC has been activated and engaged:

Over 200 people are already engaged in the Haiti response, including a number of people who were on the ground in Haiti at the time the earthquake occurred. These individuals are receiving a mere $3.00 per day incidental allowance, though they are sleeping on the ground, have no means by which to bathe, and are eating military meals ready to eat (MREs). Yet these people are highly dedicated and volunteer to go, which is amazing.

The Select Agent Program, which is managed by OPHPR's DSAT regulates all entities that possess, use, or transfer biological agents or toxins that could pose a severe threat to public health and safety. The program is designed to ensure compliance with the select agent regulations by providing guidance to registered entities and conducting evaluations and inspections. In addition, this program collaborates with the US Department of Agriculture (USDA) and the Department of Justice (DOJ) to protect public health by ensuring laboratory biosafety and security among facilities working with select agents. The program currently regulates 51 select agents and 336 entities are registered that possess, use, or transfer select agents. The program received a 100% quality rating score from the HHS IT Investment Review Board for the National Select Agent Registry; successfully merged 1.4 million records from the DSAT and USDA's Animal and Plant Health Inspection Service (APHIS) databases; provided training and guidance to the regulated community to assist entities in complying with the requirements for notification of thefts, losses, or releases of select agents; and completed the biennial review of the select agent list and posted it in the *Federal Register* for public comment.

Strategic National Stockpile

Steven A. Adams, MPH, Deputy Director
Division of Strategic National Stockpile
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Centers for Disease Control and Prevention

Mr. Adams reported that the DSNS mission is "to deliver critical medical assets to the site of a national emergency." Wrapped up in that simplistic mission are a number of complexities that fill the SNS staff's days. DSNS works within the HHS Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) requirements process to assure that they have the most appropriate countermeasures. They create pathways to move the materiel to the area of need in the timeframe that is clinically relevant. Given that initial medical responses are local, DSNS assures integration with local planning. DSNS also provides technical assistance to assure that state / local partners who receive SNS assets are ready to effectively use them; and maintains materiel in a manner that assures viability.

The program was created in 1999 and currently has a $3.5 billion portfolio of antibiotics, medical supplies, antidotes, antitoxins, antiviral, vaccines, and other pharmaceuticals that are housed in a network of strategically located repositories. Commercial partnerships are utilized for storage, maintenance, and rapid transport and federal partnerships are used for purchasing and security. The SNS contains an evolving formulary. DSNS supplements and re-supplies state and local medical materiel response; provides extensive training and technical assistance to local officials; and is integrated into a much broader national public health preparedness effort.

DSNS efforts support the inclusion of tribal governments and communities in state and local public health preparedness. Mr. Adams stressed that they were doing their best to learn from this process and from TCAC members. They do not have it right yet, but are dedicated to doing whatever they can from where they sit to encourage a reach in both directions, from tribal communities to state and local governments and vice verse, to ensure integration so that at the time of a response, the linkages are already made, planning is already done, and ideally the exercising and lessons have been learned together.

DSNS did a satellite broadcast on January 28, 2009. This broadcast was focused on partnering with tribal governments and communities during mass antibiotic dispensing. Partners in this effort included CDC's Senior Tribal Liaison, Executive Director Northwest Portland Indian Health Board (Lummi Tribe); Border Health Manager & Tribal Liaison New York State DOH; Tribal Emergency Management Director, and Poarch Band of Creek Indians. The broadcast was designed to assist state and local SNS planners in reaching out to and partnering with American Indian and Alaska Native governments. An archived version remains available at: http://www2a.cdc.gov/phtn/tribal/ and is also available on CD-ROM. Continuing education credit is available for viewing this broadcast, and the archived version continues to be accessed.

A brochure was developed to help prepare tribal nations to receive SNS assets. The division partnered with the IHS and the Phoenix Indian Health Service (PIHS). The brochure encourages tribes to work with state and local partners and the IHS to plan how to request, receive, and distribute SNS supplies; and suggests emergency response exercises. A copy of the brochure was provided in TCAC members' information packets.

DSNS has also engaged in additional tribal-specific efforts. February 10, 2009, DSNS participated in Tribal Consultation Advisory Committee Engagement Meeting in Albuquerque, New Mexico. The division participated in the Tribal Pan Flu Planning and Awareness Conference convened March 24-25, 2009 in Camp Verde, Arizona. In addition, DSNS collaborated on the development of a resource guide titled "American Indian / Alaska Native Tribal Government - 2009 H1N1 Influenza Planning and Response."

Again, DSNS is trying to take any opportunity possible to help champion the idea of integration. They began 10 years ago working primarily at the state level, and then working with the states and locals to get them to work together, and are no encouraging a more inclusive approach in which state, local, and tribal entities are working together. While this is not as much of an issue in some states, it is clearly a national issue and priority for DSNS. The division continues to look for opportunities where its Program Services Consultants, the SNS staff who are assigned to each of the 50 states, can provide on-going technical assistance for countermeasure dispensing. They are actively seeking opportunities to push the concept of integration of all. DSNS has participated in several meetings to voice its encouragement for this process, and stress the criticality of integrating all of those who would have a role in carrying out the response in the front end planning. An old adage of emergency response is that you don't want to make friends on the day of the disaster. Networks should be created beforehand, and the capabilities and limitations of all parties having a role in a response should be known in advance. This is true within DSNS, CDC, and in the broader context of integration of organizations and response.

A number of technical assistance resources for countermeasure dispensing are available and can be acquired by contacting state and local or SNS field representatives. These tools include the following:

- Formal guidance *Version 10.02: Receiving, Distributing and Dispensing SNS Assets*
- State and local exercise support and evaluations
- Classroom instruction
- Satellite educational broadcasts
- Listserv of about 4,000 people who have a role in stockpiling medical countermeasures

Further information is available at the following sites:

- http://emergency.cdc.gov/bioterrorism
- http://emergency.cdc.gov/stockpile/

Division of State and Local Readiness

Christine Kosmos, BSN, MS
Director, Division of State and Local Readiness
Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention

Ms. Kosmos reported that the DSLR administers two major sources of funding for state and local preparedness and response: Public Health Emergency Preparedness (PHEP) cooperative agreement; and Public Health Emergency Response (PHER) grant, which was added to DSLR's portfolio for H1N1 response. In addition, DSLR provides funding and coordinates technical assistance; tracks progress and evaluates performance; and collaborates with awardees on development and reporting of performance measures. One of the things that

DSLR wants to do better and has learned from the H1N1 response is that the majority of the work is done at the local, county, and tribal levels and that they need to work deeper within these organizations to better prepare the nation.

The PHEP cooperative agreement supports all-hazards preparedness in state, local, and territorial public health departments. Nearly $7 billion in funding was awarded as of FY 2009 to 62 awardees, including 50 states, 4 localities, and 8 territories and freely associated states. Tribal organizations were funded through states. DSLR is developing a new program announcement for the PHEP cooperative agreement that will reflect a capabilities-based approach that merges public health and emergency management capabilities. The new program announcement will be for a five-year program period that is anticipated to begin in 2011. A new strategic PHEP framework will be instituted to ensure that program objectives are aligned with preparedness goals, functional objectives, the existing measurement framework, the National Health Security Strategy, and the Revised Target Capabilities List.

Discussion Points

- It was noted that Dr. Hillsberg is no longer on the BSC, and that she had been replaced by someone else.

- Dr. Austin responded that the BSC is comprised of approved members who have to go to HHS for approval, so when members are swapped, OPHPR must submit a new package.

- Mr. Franklin inquired as to how DSLR is tracking whether states are contacting tribes, and if so, what they are doing about California.

- Ms. Kosmos replied that Mr. Franklin raised a very important point. CDC has had a long and strong relationship with the organizations that they fund, but those are 63 agencies. They must figure out a better plan for working beyond the state to reach the local, county, and tribal organizations to ensure that the funds are getting down where they need to be and that it results in increasing preparedness.

- Mr. Franklin said that he did not think they should be working “down” to get to tribes. They should be working across. This speaks to why tribal leaders are so concerned with the name of the Office of State and Local Support, because Tribes are not included and funds are being gotten “down” to them. Indian people die because states do not want to work with tribes and this is being overlooked.

- Ms. Kosmos apologized for misspeaking by using the term “down to tribes.” One thing that has come out in the in-progress reviews is that as an organization, CDC does not have a good platform for working with anyone beyond the 62 awardees. It has been recognized as a major gap, and certainly a gap within DSLR, that CDC does not have strong relationship with the people the states work with. However, this is where “the rubber meets the road.” Trying to get information from local, county, and tribal entities about what is working, what is not, and how much funding is getting to those levels is very difficult. One thing she has put on DSLR’s agenda is to develop a better platform for finding out this information. There must be more visibility about how things are getting implemented and what the successes and challenges are at levels other than the state. Although they do not yet know the solution, the can look to some of their work with National Association of County and City Health Officials (NACCHO) as a model. They found that states were reporting one thing, but

local organizations were having a very different experience. Thus, they developed the Sentinel Network, which is a network of 122 local health departments. This will be able to give them ground truth about what is occurring at other than a state level. Building upon that lesson learned and seeing how they can apply it on a broader level is something CDC must do as an organization, and within DSLR. As recently as a couple of weeks before this meeting, DSLR was hearing that H1N1 funding did not reach local levels. Hearing this at the back end of a response is obviously a major problem. In order for states to apply for more funds for H1N1 response, they must tell DSLR how much of the funds they were supposed to distribute very specifically to local, county, and tribal organizations. This was a directive in the guidance for dissemination of the funding. However, this was very slow to occur. They plan to develop better systems for tracking and accountability. For the fourth round of funding, states are having a very difficult time explaining how the funds received thus far have been allocated. Some states do better than others, but generally states do not have a good way of tracking the funds that they awarded; therefore, they are having difficulty accounting for this to CDC. There is clearly a lot of work to do. DSLR and CDC as an agency have learned that they need to trust and verify. They need good ground truth and situational awareness, and it must come from various points of view. They own this and will chip away at it. The situation did not get this way overnight, so it will take time to correct.

- Mr. Franklin pointed out that tribes are the most regulated people in the world, and that he could think of a million ways to regulate states and would be happy to help develop a system for accountability.

- An audience member noted that some tribes experience difficulties because their lands overlap two states, and the two states may argue over who is supposed to be accountable to the tribe. It comes down to who is going to divide funds, how much population is living where, and it is not a county.

- Ms. Kosmos replied that funding tribal nations is very difficult to sort out because of issues such as this. The funding mechanism was set up to try to push states to be more collaborative with local, county, and tribal entities. This has obviously not worked well in every case, but they do not necessarily need to “throw the baby out with the bathwater.” Funding individual nations would likely collapse DSLR because they would never have the bandwidth to do something like that. It is more a matter of logistics. Perhaps there is something between A and B that would be a better fix, such as legislation or inclusion in cooperative agreements.

- Dr. Bryan added that DSLR had done a remarkable job at taking some of their advice and putting it on the ground. The language in the guidance is very clear about inclusion of tribes with the state awardees, up to and including requiring letters from the local tribal organizations and tribal governments of concurrence with the applications as they come in, and the strong language in regard to the expectations. Many of the issues are person-power issues in terms of tracking accountability. Another problems is process at the state-tribal levels when funds are sitting in states and tribes are trying to access them. The mechanisms by which that happens have experienced many problems. There is no consistency in the way that states manage and distribute funds. Sometimes this is done through contracts based on deliverables, sometimes mini-grants are used, and sometimes population-based formula grants are utilized. A suggestion was made to COTPER in 2008 for CDC to develop best practices, standardization, or ideas if nothing else to try to systematize the process by which states distribute funds to tribes.

- Ms. Kosmos agreed 100%. In addition to some of the other lessons DSLR learned with the H1N1 response, which counted on state, local, county, and tribal organizations to stand up a response, having a cooperative agreement that relies on CDC getting money to states and states then parsing out money through contracts is an extraordinarily slow process that does not lend itself to an emergency response framework. In addition, in the midst of a response one of the things needed most is staff. However, when the funds cannot be distributed in a rapid manner to local, county, and tribal groups, they cannot hire the staff necessary to address the response. They must understand these two grants for what they are: cooperative agreements. The PHEP is basically a planning grant, which is different from the PHER grant. DSLR plans to consider whether there are better ways to fund state, county, local, and tribal organizations for emergency response. They have learned the lesson that perhaps a cooperative agreement or grant is not the best way to disseminate money rapidly. Many states do not have good mechanisms for contracting on an emergency basis.

- Ms. Hughes pointed out that tribal leaders have been making statements for years regarding why the systems and process in place would not work for Indian Country. Now preparedness discussions will be in terms of an event that can be analyzed to determine what could be done to make systems / processes more feasible for handling an event. In the early H1N1 discussions, tribes state repeatedly that those without excellent working relationships with states would not have access. This has now been demonstrated and changes must be made.

- Mr. Franklin agreed that not only did they demonstrate lack of access in many areas, but also Arizona demonstrated what could happen when tribes did have access. There are now models of what works and what does not.

- Ms. Hughes added that she is from Wisconsin where tribes have an excellent relationship with the states. They had total access in a timely manner. The day before she left to travel to this meeting, she received a report from the county, city, local, and tribal governments that analyzed what was effective with the preparedness approach to H1N1. This should be done on a national level in order to implement best practices that can help tribes where such relationships do not exist.

- Ms. Kosmos responded that DSLR is mandating an after action review, which will be required from each of the 62 awardees. Those working with state governments were encouraged to get to the table in order to inform these awardees. DSLR plans to analyze these to improve future efforts.

- Mr. Finkbonner added that he works in the Northwest primarily in three states (e.g., Washington, Oregon, and Idaho). Washington has great relationships with its tribes; however, they experienced considerable problems with both the SNS and H1N1 distribution systems (two different systems). The problems were great enough that tribal leadership engaged in conference calls and meetings with the secretary of health to discuss these issues as they were unfolding in order to address them in real time. This illustrates that even if there are good relationships in place, the system can still fall apart. There are many models, and what it really boiled down to was relationships at the local levels. These are often strained with tribes because this is where resource battles occur. When the sharing of resources is pushed to the local level, tribes typically lose because it is distributed to locals rather than tribes. What he wanted to resonate with Ms. Kosmos more than anything

regarded how to make direct allocations to tribes without other intervening jurisdictions. Public health is public health and preferences should not be made based on who someone likes or does not like.

- Ms. Kosmos said she thought that everyone who lived through this understand that there were many challenges to the H1N1 response in the areas of vaccine distribution; allocation of funds to state, local, and tribal levels; et cetera. Despite all of that, components of the response worked well. It is doubly challenging when local, county, and tribal groups do not have a trusting relationship with their state because it adds to the complexity of the response and to the feelings of inequity. She requested further input with respect to how to address the challenge of direct funding, direct allocation, et cetera to tribes given that there are so many tribes. It is not clear how to make this work without collapsing the system due to the logistical issues associated with exponentially increasing the challenges. The 62 cooperative agreements are challenging enough. Multiplying that by several times is untenable.

- Mr. Franklin suggested funding directly through IHS or Area Health Boards. California's Area Health Board would have had no problem getting information to all of the tribes in the state.

- Ms. Hughes suggested including language in cooperative agreements to require states to fund tribes directly rather than passing it through counties.

- Dr. Bryan suggested that pieces of this may work with IHS, pieces that work with states, et cetera. He does have concerns regarding some of the logistical issues with IHS.

- Ms. Manuel pointed out that it will be different in area because of the number of tribes that are in each state and county. Her reservation is primarily in Pima County, and they work well with the county, but she would prefer direct funding from CDC. When they receive a grant, it can take a year before it gets into the tribal system. She agreed that IHS could be a good mechanism, and her reservation has a good relationship with IHS.

- Mr. Trudell agreed that IHS has a system in place that could be utilized for funding distribution. The diabetes funds have been distributed to areas through IHS since the inception of this funding. Thus, there is already a model for working through IHS.

- Mr. Curley said it was not clear to him that distributing funds through IHS was the best solution, given that there have been some problems there as well. He suggested that consideration be given to allocating a specific base amount to each state for tribes, and then permit the tribes within each state determine how they want it to be allocated. This would be local self-determination. It is ridiculous what tribes have to go through to make programs work. The requirement for tribes to put together PODs only to find out when implemented that this work was not really that important, especially for small tribes. For smaller tribes this was a waste of time and manpower.

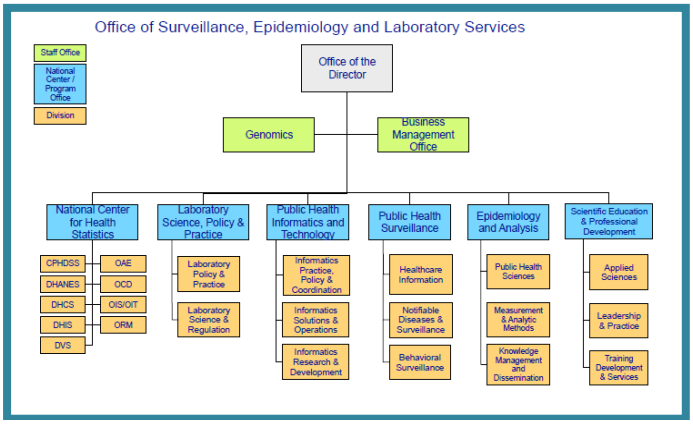
- Ms. Kosmos indicated that she would connect with Dr. Bryan with respect to further actions and how to move forward. She thanked everyone for their input, stressing how helpful it was to hear validation of what DSLR thought was occurring. This verified for them the importance of obtaining better ground truth from local, county, and tribal organizations to help DSLR develop better policies.

- CAPT Snesrud reported that on one of the conference calls, there was a suggestion of forming a subcommittee constituted of TCAC members and other interested PHEP tribal folk. This would enable Dr. Bryan to have a particular linkage if Ms. Kosmos was involved and engaged in this subcommittee. With respect to Program Consultants and Project Officers, there seems to be a circular fashion in and out, not because it is not a good place to work, but because of the overwhelming work that must be done. That said, the tribes met someone two or three years ago and have been waiting to connect. It is likely that TCAC will form a subcommittee that will look to DSLR for assistance in designating staff to work with the TCAC.

Office of Surveillance, Epidemiology, and Laboratory Services

RADM (Ret) Stephen B. Thacker, MD, MSc, Acting Director
Office of Surveillance, Epidemiology, and Laboratory Services (OSELS)
Centers for Disease Control and Prevention

Dr. Thacker shared the organizational chart of the new Office of Surveillance, Epidemiology, and Laboratory Services (OSELS):



He reported that one of Dr. Frieden's priorities is to enhance surveillance and epidemiology at CDC. Dr. Frieden is very data-driven and he was an Epidemic Intelligence Service (EIS) Officer. OSELS has a science focus for cross-cutting support of CDC programmatic activities. The Office of the Director is very small, with just a few people. The genomics program recently moved into OSELS. The Biosurveillance Coordination Unit, Behavioral Risk Factor Surveillance System (BRFSS), and CLIA have moved there as well. OSELS currently has approximately 1,200 to 1,300 people. Of those, 300 are fellows and EIS is one of the fellowship programs.

The key about the OSELS program different from the infectious and chronic disease programs is that OSELS is there to support programmatic activities and to enhance cross-cutting activities. For example, if they want to enhance surveillance activities throughout the states, OSELS has laboratory, informatics, surveillance, et cetera activities and the fellows to implement these activities in the same organization. The idea is to enhance the capacity of programs in state, local, and tribal organizations so that they can do their jobs more effectively.

Not all of the OSELS positions are populated. Most of the OD boxes have acting leaders such as himself. Their job is to implement the other of Dr. Frieden's priorities to support state, local, and tribal activities; enhance surveillance and epidemiology; use policy more effectively; translate science into practice; and enhance global health activities. HHS and the Hill have approved this organizational chart, which is now in MASO at CDC awaiting approval. Essentially this is an approved activity.

Explanation of Epi Aids & Examples from Indian Country

Douglas Hamilton, MD, PhD, Director
Epidemic Intelligence Service (EIS)Program
Centers for Disease Control and Prevention

Dr. Hamilton indicated that he is currently serving as the Director of the Epidemic Intelligence Service program at CDC in Atlanta. This focus of his presentation was sustainable public health training programs. The EIS program has been in operation for 55 years. In very simplistic terms, the EIS program is a two-year post doctoral fellowship in applied epidemiology that is targeted toward health professionals. In many ways, this program is modeled on a traditional medical residency program. The EIS program was established in 1951 with 23 recruits. In 1954, the first female officer and first Asian officer were admitted. In 1956 the first Hispanic officer was admitted, in 1965 the first African American / Black officer was admitted, and in 1968 the first Native American officer was admitted. Approximately 20% to 35% of recent graduates represent ethnic minorities. The EIS Class of 2009 had a total class size of 82 (69 US, 12 international); 27 men (33%) and 55 (67%) women, a major shift; and 21 of 70 (30%) were minorities (US / US Permanent Residents). Professional backgrounds included 41 (50%) physicians (63% with advanced degrees); 25 (30%) doctoral-level scientists; 6 (7%) MD / PhD; 7 (9%) veterinarians; and 3 (4%) RN / MPH. This is about the mix that has been included during the last couple of years.

A watershed moment for the EIS program occurred in 1955 with the Cutter vaccine incident. During the early 1950s, a formalin inactivated vaccine for poliomyelitis was developed by Dr. Jonas Salk and tested in over 200,000 children. On April 12, 1955 (the 10th anniversary of the death of Franklin Roosevelt) the availability of the new vaccine was announced. Vaccination of children began the next day. Dr. Langmuir set up a plan for surveillance for polio, largely in anticipation of vaccine failures. On April 25, 1955 a report of a baby in Chicago, inoculated 9 days earlier, developing polio was reported to CDC. An EIS officer arrived to investigate the next morning. The next day, an EIS officer in Napa California called to report a second case. By the end of the day, six cases had been identified. Dr. Langmuir traveled to Washington where he lobbied for and received permission to set up an emergency national surveillance for polio. At this time, the future of the polio vaccination campaign was in question as people argued that the vaccinations should be stopped. By May 6, 1955, vaccine produced by the Cutter company was implicated as the responsible exposure. Vaccine distribution was temporarily suspended until the factory could be checked and appropriate safety measures instituted. During this incident CDC, through the use of the EIS officers, demonstrated its ability to rapidly respond to a public health emergency.

The content of the EIS training falls into two broad areas: applied epidemiology and emergency response. The methods of instruction are very similar to formal residency training. There is a small amount of didactic material pertaining to applied epidemiology and emergency response. Methods of training include structured courses, including case studies; exercises / simulations; required activities on-the-job; mentoring; and experiential learning.

The EIS mission is to develop skills in applied epidemiology, quantitative work, research design, epidemiologic judgment, and health communications. Domestic and international service includes responding to requests for epidemiologic assistance, prevention, disease and injury control, health promotion, and capacity-building. Much of the work of EIS officers is done in experiential learning. An EIS officer's assignment may be to a state or local health department whether they will be engaged in broad, front-line public health experience; and surveillance, investigation, and intervention. Or his or her assignment may be to CDC headquarters where specialized, disease- or problem-specific experience will be gained (e.g., vaccine preventable disease, STD, injury, ectopic pregnancy); and the EIS officer will be involved in surveillance, investigation, and policy development.

One of the mechanisms the EIS Program uses is the epidemiological assistance (EPI-AIDs) mechanism. This includes providing needed service to states and other local health authorities; allowing for rapid response to public health emergencies; providing supervised training opportunities for EIS officers; and fulfilling regulatory responsibility for cruise ships. The reasons for requesting an EPI-AID include the need for technical expertise, the need for additional resources, problems that involve multiple states, and facilitated access to CDC laboratory support. It is important to understand that CDC has no regulatory control. If Ebola breaks out in New York City, CDC cannot work on it unless New York City extends an invitation to CDC to do so. The one exception is the regulatory control over cruise ships with a foreign ports of call. The criteria for an EPI-AID are that it must be requested by appropriate official, have public health importance, require a timely response, require epidemiologic methods, and contribute to EISO development. There also must be unavailability of other sources of support, it cannot be part of a planned or on-going activity. The following represent EPI-AIDS for 1999 versus 2009:

EPI-AIDs in Fiscal Years 1999 and 2009

1999	2009	
106	91	Total EPI AIDs Issued
82/4 (77%/4%)	80/8 (88%/9%)	In United States/ Multi State
2 (2%)	0 (0%)	In Puerto Rico
1 (1%)	0 (0%)	In U.S. Trust Territory
21 (20%)	11 (12%)	International

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EPI-AIDs by Subject Area Fiscal Year 1999 vs. 2009

1999 (n=106)	2009 (n=91)	Subject Area
82 (77%)	57 (63%)	Infectious Disease
9 (8%)	18 (21%)	Emergency Response
8 (8%)	3 (3%)	Maternal & Child Health
3 (3%)	9 (10%)	Environmental Problem
2 (2%)	2 (2%)	Injury
2 (2%)	2 (2%)	Other

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Infectious disease EPI-AIDS clearly represent the bulk of requests for assistance to which the EIS program responds, and assistance in this category was provided by various centers (e.g., NCID, NCHSTP, and NIP). Emergency response includes response to natural disasters (e.g., earthquakes in Bolivia, Hurricane in Dominican Republic, and flooding in North Carolina), as well as manmade disasters (e.g., lice infestation among Kosovo refugees or nutritional status

among refugees in Nepal). Over the years, CDC has begun to respond to more and more requests that do not involve the traditional infectious disease or emergency problems. Maternal and Child Health (MCH) this year has included evaluation of anemia in different populations (Alaskan Native, West Bank), evaluation of increase in uterine rupture following vaginal birth after caesarean (VBAC), and an increase in molar pregnancies in a closed population. Environmental problems this year have included trichloroethylene (TCE) exposure, and heat-related mortality in the Midwest. The National Center for Injury Prevention and Control (NCIPC) was asked to look at a rise in pedestrian motor vehicle accident deaths in Atlanta, and at an increase in suicides among medical residents. Specific examples of EPI-AIDs in Indian country include investigation of dental carries in Alaskan Native children (2009-007); an outbreak of pertussis (2007-059); three different investigators on different reservations of Rocky Mountain Spotted Fever (2005-033, 2004-061, 2003-075); an outbreak of molar pregnancies and adverse outcomes (1999-029); and adverse health effects from forest fires (2000-009).

The following map reflects the types of problems with which EIS Officers deal:

Discussion Points

- Ms. Hughes inquired as to how one gains entry into the EIS class.

- Dr. Hamilton responded that the application process is done on-line through a CDC website link. In 2009, the program received more applications than ever for approximately 80 spots. There were 430 complete applications. An initial screen is done of the applications, and the program is able to interview about half of those. There is a first cut based just on the paper application, which is really the most difficult because there is no opportunity to look at a person and talk to them. Those who make the cut are interviewed in the Fall, and a selection is made for the class in December. Typically when selecting a class, the program is looking for a couple of things. Clearly, they want the best qualified people they can get, but also they are looking for people whose interests mirror the needs of the agency.

- Ms. Hughes requested further information regarding who can make an EPI-AID request.

- Dr. Hamilton responded that some EIS officers are placed at IHS for their two-year assignments.

- Dr. Bryan added that they are assigned to the Albuquerque Division of Epidemiology and Disease Prevention within IHS where he is. This is the component of IHS that provides the core funding for the Tribal Epidemiology Centers. The EIS officer in Albuquerque has the first right of refusal for EPI-AIDs across Indian Country. The nuance is that IHS can invite an EPI-AID if it centers around an IHS facility. Even then and invitation would not go out and CDC would not come in if there were not an invitation ensuing from the tribe involved. That would either come from the principal tribal leader or his or her representative on the appropriate tribal council, or for example the Director of the Division of Health.

- Dr. Klaus said that she was familiar with a few of the EPI-AID investigations, which have largely been infectious disease-oriented and a few months in duration. She was not sure for anything not infectious disease-related when the Tribal Epidemiology Center might make a request for an EPI-AID. She wondered what the longest period of time would be that an EPI-AID would last.

- Dr. Hamilton replied that this pertained to the element of timeliness that he mentioned earlier. EPI-AIDs do not have to be just for infectious diseases. The issue needs to be a public health problem for which an immediate answer is needed. They are not for on-going research. For example, a couple of years ago the State of North Carolina wanted to change their laws about asthma admissions to emergency departments. Asthma has been around forever, but the problem was that they needed to have data within a one-month period regarding the impact of asthma admissions on emergency departments. They needed to use those data for the legislation. The state health department requested assistance to collect this information. The first molar pregnancy was noted three years before the problem was recognized as being higher than what would be expected in that population. What can happen is that a problem may be identified and an EPI-AID takes place to respond, but in the course of the investigation, other questions may be identified that lead to further research. However, further research is not part of the EPI-AID.

Wrap-Up and Closing

Ms. Hughes, CAPT Snesrud, and Dr. Bryan offered instructions regarding transportation and entry to the CDC Roybal Campus for the Tribal Consultation Session to be convened on January 28, 2010, and regarding travel home at the close of the session.

With no further questions raised or business posed, the Orientation Session was officially adjourned and the closed Tribal Leaders Caucus began.

Attendant Roster

Tribal Consultation Advisory Committee (TCAC) Members

Chester Antone, Tucson, TCAC Chair (Tohono O'odham Nation, Councilman)
Roselyn Begay, Navajo Nation (Division of Health, Program Evaluation Manager)
Joe Finkbonner, Portland (Northwest Portland Area Indian Health Board, Executive Director)
Reno Franklin, California (California Rural Indian Health Board, Chairman)
Kathy Hughes, Bemidji, TCAC Co-Chair (Oneida Business Committee)
Cynthia Manuel, NIHB (Tohono O'odham Nation, Councilwoman)
Michael Peercy, Tribal Self-Governance Advisory Committee, Choctaw Nation of Oklahoma, Epidemiologist
J.T. Petherick, Oklahoma (Cherokee Nation, Health Legislative Officer)
Alicia Reft, Alaska (Karluk Ira Tribal Council)
Dee Sabattus, Nashville (United South and Eastern Tribes, Inc., Interim THPS Director)
Lester Secatero, Albuquerque (Albuquerque Area Indian Health Board, Chairman)
Roger Trudell, Aberdeen (Santee Sioux Tribe of Nebraska, Chairman)
Derek Valdo, NCAI (from Pueblo of Acoma, National Congress of American Indians)

Other Elected Tribal Leaders

Cathy Abramson, Sault Tribe of Chippewa Indians, Board Member
Candida Hunter, Hualapai, Councilwoman
Joyce Jones, Karluk IRA Tribal Council, Vice-President
Andy Joseph, Jr., Colville Tribes, Northwest Portland Area Indian Health Board Chair, HHS Chair Tribe Council, NIHB
Buford L. Rolin, Poarch Band of Creek Indians, Tribal Chairman

Other Tribal Organizations / Tribal Health Boards / Tribal Health Professionals

Stacy Bohlen, NIHB, Executive Director
Michael Bristow (Osage Tribe of Oklahoma)
Jessica Burger, NIHB, Deputy Director
Bridget Canniff, Northwest Portland Area Indian Health Board, Tribal Epi Center Consortium, Project Director
Kristal Chichlowska, Colville Confederated Tribes, California Tribal Epidemiology Center, Director
Alan Crawford (former AI CDC employee)
Feliciano Cruz, Pascua Yaqui Tribe, Public Health Emergency Preparedness Coordinator
Larry Curley, Indian Health Board of Nevada, Executive Director
Elaine Dado, Northwest Portland Area Indian Health Board
Maria Garcia, Pascua Yaqui Tribe, Program Manager Alternative Medicine
Tim Gilbert, Alaska Native Tribal Health Consortium, Senior Director, Community Health
Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center, Director
Lyle Ignace, Coeur D'Alene, Indian Health Service, Medical Officer
Luke Johnson, Fort Mojave Indian Tribe, Public Health Emergency Preparedness Coordinator
Angela Kaslow, CRIHB, Director, Family and Community Health Services
Deborah Klaus, Navajo Division of Health, Director / Senior Epidemiologist, Navajo Epi Center

Steven Matles, Indian Health Board of Nevada, Deputy Director
Jackie McCormick, Northwest Portland Area Indian Health Board
Ruth Ojanen, Board Member, Norton Sound Health Corporation
Michael Peercy, Choctaw Nation of Oklahoma, Epidemiologist
Geoffrey Roth, National Council of Urban Indian Health, Executive Director
Paul Saufkie, Hopi Tribe, Public Health Emergency Preparedness Coordinator
Audrey Solimon, NIHB, Senior Advisor, Public Health Programs
Berda Willson, Norton Sound Health Corporation, Board Secretary

Centers for Disease Control and Prevention

Steve Adams, Deputy Director, Division of Strategic National Stockpile, OPHPR / CDC
Larry Alonzo, Commander, US Public Health Service
Annabelle Allison, Environmental Health Specialist, NCEH / ATSDR
Lynda Anderson, DACH / NCCDPHP / CDC
Lynn Austin, Deputy Director for Operations, OPHPR / CDC
Mick Ballesteros, Associate Director for Science, National Center for Injury Prevention and Control
Holly Billie, Senior Injury Prevention Specialist, National Center for Injury Prevention and Control
Nell Brownstein, AREB/DHDSP/NCCDPHP/CDC
Kristen Brusuelas, Chief of Government Relations, State and Local Services
Ralph Bryan, Senior Tribal Liaison for Science and Public Health
Pyone Cho, Epidemiologist, NCCDPHP
Christine Kosmos, Director, Division of State and Local Readiness
Alex Crosby, Epidemiologist, Division of Violence Prevention, NCIPC
Linda Crossett, DASH/NCCDPHP/CDC
Larry Cseh, ATSDR, Environmental Health Scientist
Sean Cucchi, Associate Director for Policy, NCCDPHP
Rob Curlee, Deputy Director, Financial Management Office
Lori de Ravello, IH S / Division of Epidemiology & Disease Prevention, Public Health Advisor
Roseanne Farris, NCCDPHP / DNPAO, Branch Chief
Michael Franklin, Senior Public Health Analyst, Financial Management Office
Donna Garland, Acting Director, Office of Communications / CDC
Larry Gilbertson, Public Health Advisor, NCCDPHP
Doug Hamilton, Epidemiologist, EIS Chief, OSELS / CDC
Christine Kosmos, Director, Division of State and Local Readiness
Dianne May, PSB/OSH/NCCDPHP/CDC
Marcus Plescia, Director, DCPC/NCCDPHP/CDC
Louis Salinas, Chief of Staff, OD/ CDC
Dawn Satterfield, Native Diabetes Wellness Program
Mike Snesrud, Senior Tribal Liaison for Policy and Evaluation
Stephen Thacker, Acting Deputy Director, Office of Surveillance, Epidemiology, and Laboratory Services
Myra Tucker, Tribal Liaison
Karen White, Acting Deputy Director, Office of State and Local Support
Lorraine Whitehair, Division of Nutrition, Physical Activity, and Obesity / NCCDPHP
Craig Wilkins, AI / AN Team
Walter Williams, Office of Minority Health and Health Disparities

Other Guests

Stacey Ecoffey, Principal Advisory for Tribal Affairs, Intergovernmental Affairs, HHS
Brenda Granillo, Director, Arizona Center for Public Health Preparedness
Ronald Demaray, IH S, Acting Director, Office of Direct Service and Contracting with Tribes