May 11, 2023 – ACD Meeting Transcript

This is a test for captioning.

>> Please note the closed captioning link has been provided in the chat box for your convenience. I'm delighted that I'm actually able to be here today. I thought I was going to be in D.C. for a hearing but I'm able to be here and I want to thank Tiffany brown, who until the last minute, was planning to step in and had done a huge amount of leg work and logistics around this. You will also note that Dr. Walensky is not here today.

She sends her regrets as she's testifying before Congress in about an hour so she's unable to be here this morning. She regrets, you know, that she couldn't be. She really enjoys these meetings. I did just want to touch on the news before I turn it over to David to run the meeting is that Dr. Walensky announced on Friday she'll be leaving the agency at the end of June. She's had a tremendous impact in leading our reorganization and all the moving forward updates as well as leading cdc and the nation through many things like Covid, mpox, ebola and more. I personally want to thank her and I know we will miss her. The administration will determine who the next director is and I don't have any more information at this time. I just wanted to let you all know that so there's not questions throughout the meeting on this. And I'll now turn it over to David to start the meeting.

>> Thanks, Deb. Welcome, acd members and everyone present today. It's great to see all of you. Just briefly, Deb and cdc, I'm sure I'm speaking on behalf of all of the acd committee in expressing our appreciation to Dr. Walensky for her leadership and reinvigorating the acd so thanks. And we look forward to continuing to work with all of the great leadership that's in the office of the director and throughout cdc as our new leader is identified. We have a lot to do today so let's get started.

Let's start with the roll call.

Just do a quick roll call. We have members going in and out today and so we're going to recognize that. I'll start. I'm present and I have no conflicts of interest.

>> I would like to just acknowledge the energy in this room. I have a number of visitors in the room.

>> Thank you. Absolutely. I would like to introduce you and I'm happy to have you for a second year in the row. Thank you to cdc for hosting us.

Dr. Ryan sutton, also Lori hall, academic program manager of the university of Texas at Austin.

Ryan is the medical school and 13 students from the university of Texas who are all interested in the health professions, they are either first gen and/or from historically marginalized groups and we're here to increase diversety of the health care work force. Thank you.

>> Welcome. It's nice to have you here today. We'll be busy this morning. This -- just as a reminder for folks, if during the presentation or during the question and answer period if you have a comment, raise your hand. We can see you here. If we're not seeing you, feel free just to speak up and interject.

The first update today is going to be from the office of the director and then just to round that out, we'll have a report from the health equity working group, an update from the new office of equity and then update and report from the office of readiness and response. We'll break for lunch. In the afternoon, we have a report from the global health programs, a report and a vote by the data and surveillance work group and a report and a vote by the laboratory work group. So we have a full agenda today and for those of you keeping track, the communications update originally scheduled for discussion today, we're going to postpone that to a future meeting. And finally, the February minutes are on the website as are the reports from the working groups and please feel free to check those out.

Now let's get to work. And it's my great, great pleasure to introduce Dr. shah who is the principal deputy director since our last meeting. Dr. shah will be providing the agency update this morning. And yes, if you are wondering, we do have two Dr. shahs on the agenda today.

The principal deputy director who we're about to hear from and the acd member and the other who will be presenting this afternoon's report on data and surveillance. You have it for us.

>> Thank you, David. Good morning, everybody. What a world we live in. Good morning, everyone. My name is nivav D.shah and I'm the principal deputy director. I want to shout out to the students that are here. Thank you all for joining us. Thank you all for being here with us today. I am ready to set the table for a few minutes before we turn it to --

[Inaudible]

first of all, as Dr. Walensky sends her regrets, she's testifying to the approach to readiness, something we'll be discussing today as a committee.

She sends her regrets and unfortunately cannot be here.

Were she here, she would want to thank all the A.C.D. members for their time and for their commitment to advising cdc and making the agency even better than it can be. We're -- meeting today on an interesting day.

It's the end of the federal public health emergency. As we all know, although the mechanism of the public health emergency is ending, Covid most certainly is not and I certainly don't have to indicate to anybody who is in this room or watching that Covid was a transformative episode for the cdc. Now that the emergency phase is over, we at the cdc are working to integrate Covid

19 along with other respiratory viral pathogens within the national center for respiratory diseases but the end of the Covid 19 public health emergency also presents an opportunity for the cdc to move to the next phase and there are open questions about what this looks like. How do we avoid mistakes that were made in the past? And again, how do we accelerate some of the progress that was started during Covid 19? The answers to the questions are largely provided by Dr. Walensky in the form of the moving forward initiative.

Moving forward initiative is designed to make both structural changes to improve cdc efficiency as well as operational goals to improve the way we communicate, that we share science in real time and that we ensure our work force is ready for the next pandemic whenever that may be. Not withstanding the promise of moving forward, challenges remain, however. Trust in the cdc as an institution, trust in public health as a profession, trust in us has waned, unfortunately, during the pandemic. That trust may make it much more difficult to advice the public on safe steps they can take when the next pandemic happens. There are challenged we face in ensuring that funding for public health at a national and international level, not just remains steady but perhaps even sees investments. In the military when times are during peace, the military uses that time to invest in building materials, training troops, making sure they're ready for the next engagement. That is theed work that lies ahead of us for the public health enterprise as a whole and it's the work that we are committed to doing here at the cdc. We're going to be talking and touching on many topics today, starting with a discussion about health equity from our colleague, trying to understand how better to measure our work around health equity and then how to put action steps into place to advance the work there. We'll then be joined by Dr. wahl to talk about the cdc response and readiness posture as we all know another pandemic is just a plane flight away. We have to be ready to respond scientifically as well as from a communications perspective.

Closely tied to that is our portfolio around global health which Dr. zucker will be briefing on. Where are we around the world understanding what is happening and making sure that we can stop the emergence of a pandemic before it finds its way on the plane. Closely tied to that is making sure we have the appropriate data and surveillance, to understand not just what's happening in the U.S. but around the world. My colleague, Dr. shah, will be leading that discussion and joined by Dr. laden from our team and then our laboratory work. A core piece of the moving forward enterprise, one that I'm deeply involved with right now and I look forward to hearing that rich discussion from our doctors as well as laboratory colleagues. Thank you for your time today. There's much exciting work happening. We're excited to talk to you about it and understand how we can take it to the next step, with that I'll turn things over for any brief comments.

>> I want to add a couple of updates from our last meeting.

The first time cdc had looked at the sickle signs, it's a great topic to talk about what cdc can do, what are the health care disparities, many of you saw the youth risk behavior surveillance release on youth, particularly teen girls and the amount of violence they are experiencing.

I think that was a very disturbing report and so much that we can continue to do. Our staff are certainly involved in the infectious diseases but I wanted to highlight some other responses. East Palestine train derailment, our staff were very involved in that and many other environmental exposures. Our niosh colleagues are involved with in Michigan with the paper mill and then chronic is involved in things like the cancer moon shot. As I was preparing for what I thought was going to be a hearing next week, I learned about how our public health infrastructure grant really supports what states need and the two examples that struck me were in Georgia where we're training public health nurses to train in infections and child visits. Showing how when states and communities have a need, they're able to do it similarly with Tennessee. They now are doing home visitation programs, particularly in counties where there's high rates of maternal mortality and infant death so using the funds from the cdc so the public health infrastructure GRNT to address parties of the greatest need and the last thing I wanted to mention is that as I've been -- you know, was reading on maternal mortality, we lost a great colleague last week in maternal mortality due to the shooting last week in Atlanta. She was the cdc staff member. Her memorial service is tomorrow. Amy saint Pierre so I wanted to recognize her for her efforts and for the loss of the public health community and to cdc. Thank you.

>> I'll open up the floor for questions our comments for acd members. It's a little hard to get our minds.

>> I know Dr. shah probably answered anything last night but if there's anything else that you slept on and would like to ask, we are here.

>> I'll ask a question while people are thinking and you referenced the fact that public health emergency is ending today. There's been a lot of media about the consequence of that and our ability to track health conditions and do surveillance in that country. We all know that surveillance is something that existed before Covid and continues now. Could you talk a little bit about what cdc is able to continue to do and also if there are any things that are worrying you that we should be focusing our attention on that are potentially dropping off the table as a result?

>> Thank you, David. And I might tap in my colleagues to provide additional color. You're right.

The end of the public health emergency means that cdc's ability, authority to access certain pieces of data from jurisdictions, hospitals and laboratories comes to a close.

Let me first talk about what our level of surveillance will look like first and then talk about and tie that to this piece around having data authority.

Going forward, some of the pieces of data that individuals across the country were used to seeing will be different. It won't necessarily be going away altogether but they will look different. One example of that is our community levels. This is a map that a lot of folks are familiar with that is driven in large part by hospital admission data but in small part by Covid

case rates. The end of the public health emergency means that laboratories at state and local levels will not be reporting individual Covid cases into us. Now, we'll still have data files from states but that laboratory reporting coming in to cdc will come to a close. As a result of that, the Covid case levels map will also come to a close. It will be replaced, however, by a map solely driven by hospital admission rates.

That leads to the natural question, how good is that map?

Scientists at the cdc have back tested the performance of both of those maps, community levels and just the stand alone hospital rates. Going back to the inception of the community levels in February of 2022. And as we published in an mmwr on Friday, it turns out that the Concordance between the two is 99%. That's to say relying just on hospitalization data alone which we will continue to have for at least another year, gets you 99% of the way.

Hospitalization data, as we all know, come a little later in the course of a potential surge. So we don't rely upon that solely.

We rely on a number of metrics.

For example, on the early side, we will continue to have robust waste water surveillance that covers about 130 million people in the country. We'll also continue to have some drone surveillance diagnosis data from ed's around the country. We will also have a modified form of positivity rates from a laboratory network that's run out of ncird around may 25 and then, of course, we'll have the hospitalization data. So we'll still have a good view into what's going on with Covid even though it will be different.

None of that, however, should be taken to say that our work around data and data modernization and data authority are done. We should still have the ability to access these types of data so we are ready to go for the next type of pandemic to in short, our goal is for us to be ready so we don't have to get ready when the next pandemic hits. Anything?

>> Nailed it.

>> The one word you didn't mention is genomic surveillance.

I saw a report of an academic researchers saying the potential for surge in the fall and winter so how are we covering that?

>> Great. Thank you, Dr. Taylor.

There will be -- genomic surveillance will be taken and reported in the now cast feature on the cdc website. I will get -- it's on my laptop. I will get the precise number as to how many sequences per week we are expected to be sequencing. It is on a slide that I committed to memory last Thursday but I've since forgotten. There's a number. Do you happen to remember? We'll find out. It's in a note that I have. But there will still be what we believe to be a robust around of genomic sequencing. It's not the same as before to be fair but it will allow

what the purpose is which is robust surveillance in the possibility of incoming variants. Two notes there, one is that one program that will be maintained is our efforts to screen on a voluntary basis passengers who are incoming from various international flights and then sequencing the sub types if they test positive, number one. Then number two, we're also starting our program, started yesterday, of conducting waste water surveillance testing at right now one airport but soon to be more airports of international entry. In tandem we'll have good insight into the possibility of variants arriving or emerging in the U.S.

It won't be what it was before but it will still be sufficient from a surveillance perspective.

>> Thank you. That is comforting. The influence of the program, as I understand it, has a right size approach to surveillance. Are we approaching that for Covid given that we don't expect it to go -- we certainly aren't eliminating it so is there that sort of approach for Covid?

>> That is the intention, Deb, if you want to weigh in here but that's the intention and based on incident management team meetings I've had and the folks with whom I've spoken there, they believe in tandem, taking all the various multitude of metrics together, we will still be able to maintain site lines into how Covid is unfolding across the country. There is not one single metric at the moment as there may have been during different times previously. It will take sort of an all global view. We'll continue to publish those data on our Covid dashboard so they'll still be publicly available and I think in tandem, they will still provide us insight as well as in early morning when certain regions may be experiencing strain.

>> Thank you.

>> Let's go to crystal and then Josh.

>> Yes. Dr. shah, another thing on minds are the debt limit discussions and --

>> The what?

>> Debt limit discussions.

>> Yes.

>> I'm wondering if you can speak to how cdc is planning for the possibility of reduced funding, either because a deal is not reached or because a deal is reached but results in significant reductions in discretionary spending.

>> Thank you. That is very much on our minds right now and as you noted in the stem of your question, no one is quite HUR how and what form it will shake out. What I can say is that we are working very closely with hhs, our own budget office as well as our colleagues at the White House to first make sure we understand what the nuances and the contours of the discussion is. Second, try as best we can to minimize any potential impact on cdc and then third, try to mitigate whatever that might be. To be fair and to be sure, if there were not a deal reached, consequences would be far reaching across the U.S.

cdc included. Right now we're planning for whatever eventuality that may take, working and getting direction from the colleagues at hhs but given that it's changing almost every hour, you know, I can't say much more other than to assure folks that our financial folks, budgetary folks are staying very clued in.

>> Josh, then Michelle, then octavia.

>> You came to this job after being a state health officer in states with big urban area and large rural areas. I'm curious what your perspective is having come to cdc. What do you think people don't necessarily appreciate about cdc or you didn't appreciate until you got here?

>> Yes. Thanks, Josh. You're right. In my previous two posts I had the privilege of being in two different state health departments, one in Illinois and another in Maine and as you noted, both states had very different complexions and both had an urban component and rural component. Coming to the cdc with the national per purview is all of that times ten or times 100. One of the things that emerged for public health in general but perhaps for the cdc in particular, there's still not a lot of clarity across the country into what cdc does or rather, what we don't do.

There's still impressions that we are a health care entity rather than a public health entity. There's still the notion that we provide individual patient care, et cetera, so one of the things that I'm hoping to be able to do is to make the words public health and population health more synonymous with the cdc as opposed to reimbursement mechanisms and such.

>> Maybe one quick followup.

>> Yep.

>> What do you think you wish people understood about the way the cdc really supports front line public health organizations? I found that people who may be don't have a great conception of the cdc, when they need public health, they know they're usually going to local or state health departments and it's a little bit, often removed from the political fray because they need to get an inspection or something to see if it's safe or they have a concern about an outbreak right there in their neighborhood. What do you wish people knew about the cdc in terms of how it relates to the other jobs and just public health in different kinds much communities across the country?

>> Thank you for that question.

What I wish there was more of a finer and more detailed understanding of was the reality that cdc is meshed with each and every one of those state and local health departments on a very fine level. Initially through a funding approach. I mean, much of cdc's appropriated Congressional budget goes directly to state and local health departments so there's a fiscal relationship but then more importantly, the professionals here at cdc are literally standing by

the phones to take phone calls from state and local health department leaders any time something new or different is happening.

There's a notion that the cdc is different from what's going on when the reality is we're joined at the hip side by side. A better appreciation for that relationship would be really helpful. I'm reminded and many in this room, many years ago at a meeting when at least Dr. Dr. zucker and I were state officials, we were listened to a statitician at Harvard who was sharing data where he asked individuals in the United States, do you know what your state health department does?

And the answer was resoundingly, no. No. Then later in the survey, do you think your state health department is doing a good job? No. No. So the lesson is a lot of people in the United States don't know what their state health department does and they're convinced they're not doing a go ahead -- good job at it. I think we have work to do to try to repair that.

>> Thanks. Dr. Albert?

>> Thank you. Dr. shah, many leaders think that misinformation is the greatest threat to public health as well as the greatest threat to --

ongoing threat to the propagation of the communicable and non communicable diseases.

Could you tell me, tell us your thoughts about some of the principles around emergency responses to misinformation as well as sustained responses related to misinformation? And any associated diagnostic strategies to combat misinformation?

>> Thank you, Dr. Albert. You're certainly correct.

Misinformation is a concern for anyone involved in public communication, particularly public health as we saw unfold during the pandemic.

Misinformation leads directly to degradation of trust. Trust in the work that the C.D.C. does, trust in the guidance that we provide and trust in the ability of the products that we evaluate and recommend such as vaccines to do the job that they are doing. So misinformation, disinformation are concerns that we are addressing. We're also trying to make sure we're staying ahead of those possibilities so one approach that we have taken more recently is to get ahead of the possibility of misinformation flourishing. One example that I can offer around that, two examples, one was just a few weeks ago when a particular strain of avian influenza was detected in a human patient in chile. This strain, to a lay person, might have appeared to contain certain mutations that could lead someone to fear it would cost widespread transmission. Recognizing that fear and the possibility of misinformation, our scientists at the cdc spoke with people, spoke with the public, spoke with reporters and put up on the website clear information before any of those misinformation based stories were able to take root and spread. Another example came a few months prior to that when a very, very faint signal was detected with an association between the Pfizer Covid 19 vaccine and the possibility of stroke.

So there's a faint TIG natural but in the interest of scientific integrity, we wanted to make sure people were aware but we framed that entire process with what we knew, what we didn't know and what we were doing to find out. As a result, that cut off the possibility of widespread misinformation flourishing. I should note that subsequent detailed analysis has confirmed what we all suspected which is that there is not a link between the Pfizer vaccine and a stroke but getting ahead of that, anticipating what the possibilities for incorrect information were and then putting that out there along with the message itself were good examples of how we are cutting misinformation off at the pass.

>> Thank you. Could I just follow up with a quick question on that? It seems to me the approach -- and that's fantastic work -- have been tactical, right? Is there any work that is going on that is more sustained to deal with just the background, you know, levels?

Because I feel like it's the background levels that actually have an outside effect.

>> Agreed and thank you for that. I completely concur. We're thinking through what effective strategies to cut misinformation off at the pass, what those might look like. Right now our approach is exemplified by the two examples I mentioned, sort of prebunking or anticipating what common threads of misinformation may look like and ensuring those are signalled and disputed and put to bed before something was really allowed to take hold. That's our strategy right now. Putting out proper information rather than waiting until misinformation flourishes.

There's an old mark Twain quote that a lie can travel around the world before the truth has had even time to get the sneakers on so our approach is to try to get the truth out the moment the information comes out with it.

And before I turn things over to the next question, Dr. Taylor, to go back to your question, I did confirm that on an ongoing basis, cdc as well as other genome sequencing in the United States will be producing 10,000 genomic a week around Covid 19.

>> Thank you very much. This sets up the basis for emerging pathogens so we'll have the infrastructure.

>> Indeed.

>> thank you.

>> Last question from octavia.

>> Dr. shah, turning your sort of vision toward our southern border, especially with Mexico given the phe and the expiration 42, there's a lot of angst along the -- in Texas especially where I'm from, people making exclamations or comments of there's going to be an environmental disaster. I'm just wondering from your thoughts the role of the cdc and how many, you know, could tamper the information as well but just wanting to know from also just a perspective for Mexican border but also, you know, for others even with our cdc roles with china and stuff like that, what's happening now with phe.

>> Thank you for that question.

We're certainly closely tracking how the end of the public health emergency and thus, the end of title 42 will affect the public health conditions along the southern border as well as how those conditions may move elsewhere as things unfold. We will do what we've always done in situations like that which is, if there are concerns from the public health perspective, we will make sure that we are working with the state and local health departments to respond to them. This is not a situation in which we would be in a new world. This is something that the cdc has interacted with in previous situations. We have a robust set of programs around migrant health, traveller health, rural health, all of which can be brought to bear on those situations as they unfold.

Thank you. Thank you for raising that question.

>> We are out of time so we need to move on but really, want to thank you, Dr. shah, for being here today answering questions for being at cdc and for your leadership. We appreciate it and look forward to working with you before and during our next meetings.

>> Thank you for your service and I'm looking forward to discussions today.

>> Before we move on, I would like to acknowledge that Dr. Hardiman is with us and would you willing to declare any conflicts of interest?

>> No conflicts.

>> Thanks. Great to see you.

We're going to move on. Next part of our agenda we'll hear from our health equity work group with both a report and a vote. Dr. Monica lupi and Dr. Daniel doss. I'll start off by turning this over to you, Monica.

>> Thank you, David. And thank you, everyone. And definitely sending along apologies from Daniel who wasn't able to join us. As you probably heard, since we last met, he's taken on a new leadership role to lead the development of the global school of public health so he spends along his apologies. Next slide, please. So I want to thank David again for jumping in and helping to copresent and for his help in working with the work group members in developing upgraded one and two recommend ages for the acd consideration and I want to acknowledge our wonderful acd members who have really actively participated throughout the discussions and conversations and also acknowledge our public members. We're OBL able to return this morning with updated action steps because of all of the thoughtful participation of our work group members so thank you. And also want to acknowledge and appreciate the support and skilled guidance our cdc colleagues have offered. So Tiffany brown, our dfo, Brigette Richards and Jennifer winey. So just a reminder, we had three task areas and the work group broke out across the three task areas and you'll see the description of the charge for each of the groups. So task area one was really focused on ensuring meaningful community engagement, task area

two was folk used on aligning and restructuring policies, practices and procedures and the final task grade was looking to aim expanding and embedding social determinants of health measures across all public health programs at the cdc. I want to spend a few minutes to recap the work to date. If you recall, we presented proposed action steps for all three task areas and the acd adopted task area three action steps and asked that the hew return, regroup and do some additional work on task area one and two.

Mainly it was because those were related to community engagement and then the policies, procedures and practices. Mainly because what we understood the task to be was that there was fairly high level language in the proposals as drafted and that it might be challenging to implement without more detail and specificity so following our February meeting, David Daniel and I regrouped with our cdc team colleagues to help us figure out a plan of course to help us tailor more action steps that would be actionable. Sorry I keep saying actionable but what we did was, we drafted some specific questions for our cdc subject matter expert colleagues to help us better understand how cdc programs were currently partnering with communities and how funding and other resources were being deployed to communities through the notice of funding opportunity process and we are excited that last month, in April, we were able to hold a virtual meeting with the work group where we had presenters from the cdc offices of appropriations which sits within the office of financial resources, the performance and evaluation office which sits within the office of policy performance and evaluation and also the office of grant services which is within the office of financial resources.

It was a really robust discussion, lots of good opportunity to ask questions of our cdc colleagues and that information we went back to the drawing board, synthesized and used the discussion to help draft updated action steps for your consideration and implementation. So as David said, we're going to tag team the presentation to you. I'll hand over to David who will walk us through updated proposed action steps for task area one.

We'll pause, have discussion and then move towards a vote and then it will come back to me to provide some updates on task area two.

>> Great. Thank, Monica. And just to reinforce, we're going to be splitting this into two separate votes because it's two different task areas. Assuming that these go forward, we are going to then combine these with task area three and to a comprehensive report. That's the best way we decided to do it. As Monica mentioned, task area one was really around the issue of community engagement and community governance and how to better assure that in cdc and state and local programming.

Very briefly, working with task area, we established some guiding principles for community engagement and thanks again to the Task Force members but basically, I think they're straight forward. First to ensure that we create systems and processes that allow community perspectives to lead and to ensure that communities are meaningful included throughout the decision making process. Second, to build on strengths that match solutions to communities

rather than thinking this is a sun size fits all, communities are different and let's build on strengths.

Third to recognize that this is a long term effort and health equity occurs across the lifespan and is influenced by multi generational experiences of trauma along with racism, ableism, sexism, classism, homophobia, et cetera, and we need to take into account and adjust our interventions accordingly and finally, that if we're going to achieve that positive change that we need to achieve, let's make sure we're mapping the effects of drivers of health equity and making sure our interventions are focusing on the well-being of the affected populations. Centering on that community development and sustained investment is what we need to make a difference. So to move forward to the proposed action steps, this again, it would be -- let's go to the next slide. And the key issue here is really to recognize as a result of some of the work that the work group did since the last meeting that it is important in the cdc and any government to ensure that any entity in line for funding is not involved in the final decision making process about who it is that receives awards. But it turns out that short of that, there's considerable latitude and freedom that the agencies, including cdc have to engage communities. And in retrospect, perhaps we've been as an entity, cdc has been a little hesitant to engage communities but there are some specific action steps that are ones that we think would make sense. I would like to run through those. This proposed action set is directed specifically at cdc and we're suggesting that cdc takes some specific steps to build and strengthen its relationship with the communities and community based organizations. Two slides here. The first three steps potentially were to create an external council, a process to provide advice and perspective from diverse communities to the cdc new office of health equity and the cdc as a whole. Second, to engage in a process with community based organizations to solicit their perspective and advice that challenges they face in working with the cdc and receiving funding from the cdc either directly or through sub GRNTing from state and local health departments. Third, to make a concerted effort to include diverse community and cbo perspectives and the membership of the cdc advisory communities to really make this an agency wide issue. Next slide. Three more steps to this proposed action area one. The fourth would be to routinely include appropriate community and cbo perspectives in all of cdc external program reviews and public health issues meetings and convenings that engage outside partners. To include and prioritize the inclusion of lived experience as a potential job qualification and job announcements and position descriptions for internal staff who create and oversee public health programs. And finally, to develop and encourage opportunities for internal program staff here at cdc to experience the realities and the challenges of underserved communities and the community based organizations that support them. Moving on to proposed action steps two, the next slide, this is really a complementary effort in that we're proposing that cdc should prioritize engaging with state, local, tribal and territorial public health departments to really identify and implement best practices to build and sustain and strengthen relationships between stlt agencies. As someone who has worked at the stlt level, I think most agencies would say, yes, we have relationships

with communities but no, they're not as strong as they should be and we need to take steps to strengthed -- strengthen them.

We need to provide leadership and better connecting with communities as we just talked about in the first proposed action step. It's a model that practices for public health departments connecting with communities. The second could be to look internally and identify and implement ways to harm ONize and practice expectations across cdc programs so that we can optimize community engagement at the stlt levels. This is ensuring that grants have the amount of time needed in the application process to adequately engage communities, to use common processes across grants for working with communities and to prioritize the use of local metrics. To enable communities working on multiple cdc grants on the same underlying conditions to adopt common practices in doing that.

And potentially to, at a minimum, encourage and optimally an agreement on approaches from relevant communities in grant applications. Third proposed action step is to work with stlt public health agencies and community partners to identify best practices for mechanisms to ensure community engagement and leadership and then to encourage and/or require adoption of those practices by stlt public health agencies in the relevant cdc funding streams. And finally, to actively seek to identify and create opportunities, including funding opportunities foreign abling that meaningful engagement between stlt public health agencies and communities especially on issues relating to underlying drivers of health equity. There's a concept called disparity impact statements that they encourage the use of and our working group would enforce that which is basically saying when funding has been given to an entity that after the fact to provide funding to the agency to engage in a direct discussion and work with the affected communities to assure that there's opportunity for community involvement, to assure that strategies are data driven, including data being defined as qualitative input, including lived experience and to specifically address how the project is going to affect those communities that are at highest risk. Those are the proposed action steps. The north star we wanted to put forward is that the critical determinant for determining cdc success in task area one is going to be the recognition, that meaningful community engagement is more, right, than just fostering communities for the community to provide input and instead, requires community agency in the policy, program development and implementation. So with that, I'll conclude this part of the presentation and before moving on to task area two would open the floor for discussion or input on this area and optimally to provide to a vote. Josh?

>> Thank you. And thanks to the work group and for excellent recommendations. I think in these things, it's kind of hard to get to like actionable recommendations that are like kind of like shovel ready as opposed to aspirational directions for the agency. The recommendations about really encouraging local and state health departments to do better, that's really important recommendation. I think that there are some very specific mechanisms that cdc could use for that and I would just point out that there's a 3.9 billion dollar grant right now with funds for a number of state and local health departments that has a big emphasis on foundational public

health services. Among those are equity and community partners of development. And one of the concepts that have been floating out there within the Commonwealth commission report that I was part of is that cdc through that funding could have some expectations and structure the evaluation around the foundational capabilities in a more specific way. This could be an example of that. So if you have the goal of encouraging that somewhat aspirational --

it's an action step but how do you do that? There is -- you know, there are a number of agencies that have been charged with, you know, moving in this direction, a lot of money going for work force and having the cdc be a little more specific in maybe the instructions, technical assistance partners and the evaluation for how those funds could be, you know, to build the foundational capacities for the health department to do this kind of work may be a way to make it more tangible.

>> thanks. A great comment and we can work to include these kinds of important changes in a final document. I would ask you to hold that thought a little bit because the second part of this presentation really deals directly with the concept of funding opportunities that cdc is letting out, how practice might change. We will get to that with Monica. It's a really, really good point. octavio?

>> Thanks, David. I want to emphasize the concept of the external council to the new office of health equity. I think it has a lot of potential if --

when it comes to implementation and to the other steps that come along because really, as you look at those action steps, I would hope that that would be one of the very first things we would need to do. With the expertise coming from communities can really help with community engagement and really following through with these. So I think it would be a wonderful development especially for your office of health equity. We'll hear from them later but I think it could be such a powerful mechanism. I have a national advisory council for my foundation, the heart foundation for mental health and I can tell you the tasked individuals and much like this group with real action and work and get the right folks at the table, you can get a lot of work done.

>> Thanks. Any other questions or comments on this first section? If not, Monica, I would entertain a motion from you.

>> This is the part where I ask members if there is a motion to vote for moving the proposed action steps from the work group for a vote -- for a recommendation for a vote.

>> So moved.

>> Second.

>> Any further discussion? If not, I might ask all the acd members to signify by aye if they're in support.

>> aye.

>> opposed? Are there any abstentions? If not, the motion carries. Michelle, I want to make sure that was raising your hand to vote yes versus a question. Yes. Thank you. Great.

Congratulations to the work group. That's very exciting. And now we'll take a deep breath and Monica, you're on for number two.

>> OK. So this will get to the discussion about shovel ready so hold on. So task area two, we're on the slide with the title, guiding principles. So next slide. And then the next slide, please. So without reading all of this and you have the full details in the report, just wanted to elevate that the bottom line is we recognize that structural barriers have prevented community based organizations from accessing cdc resources with financial technical assistance and just the connections and collaborations with all the support matter experts here at cdc and that communities and equity should be central to the development of policies, programs and funding and that we really need to SKRES efforts to strengthen and expand opportunities for cbo's to apply for and receive these resources directly and we've already heard that much of the funding flows through the stlt public health agencies or not, to community based organizations and all the folks on the ground who are delivering and also receiving really important public health services. Next slide, please.

The guiding principles continue on and they were tweaked. This one actually, I think, several of the acd members and work group members contributed to some reVIGs to make sure that we're emphasizing the need for cdc to -- and we know that you've been doing this but just to underscore the need to examine and revise existing policies and laws for the existence of stigmatizing language and to ensure that new policies stop further stigmatization. I also know that from having worked in both a local and a state health department that unless you institutionalize equity practices into all decision making, it will be optional for some programs and staff and that's not because equity in addressing health inequities isn't important but because oftentimes it's the culture and the practice of the day-to-day so you'll see throughout the guiding principles an elevation of institutionalizing all of this work across the board from the office of the director to the cio's to ensure transparent accountable, accessible and inclusive process that helps both internally and in the ways that you work with your stlt agencies, community based organizations and many partners on the ground who are part of the public health enterprise.

And there's also with the last bullet an emphasis on need to go scale equitable practices and throughout the process of developing the proposed action steps, we were able to hear from many different cdc programs about ways in which they're taking the work of equity and addressing those upstream factors that address social determinants of health and delivering programs and resources in different ways so scale is another important consideration that the work group elevated in the guiding principles. So next slide, please, moving on to the updated action steps for task area two.

We, as a work group, and this is to acknowledge that there has been, as part of recognizing racism as a public health crisis within the organization, the moving forward initiative that there already has been progress and a lot of energy underway to address equity so this is building on those. The work group is proposing that cdc immediately initiate a coordinated agencywide assessment of all the grants, cooperative agreements and contracts across all programs, projects and activities or ppa's to establish a publicly available and accessible inventory of how funding is distributed, whether it's competitive or formula-driven, et cetera, to which types of organizations. We know that the majority currently flows to stlt public health agencies but there are examples where the nofo's are available and cbo's are eligible grantees, the cooperative agree manies and then this piece is important and this is what we learned from our content experts. Where there may or may not be restrictions in the legislative language concerning the eligible grantees. Furthermore, a second piece of this action step is that ROOE we're proposing the cdc develop an inventory which identifies the names and specific award amounts for the primary grant sub recipients for all grants, cooperative agree manies and contracts that are A awarded so in the case of funding flowing to stlt agencies, I think I recall up to 40% of that funding could have flowed to locals but how much of that funding then goes from the locals to the cbo's to help support the foundational capabilities in other public health services so we're asking not only for top level details from the cdc but in the sub recipient process. This is really different than what is currently on mind. We had a chance to go online and look at the state by state profiles, the funding profiles which is helpful but it doesn't provide the level of granularity that the work group is seeking and would be helpful in terms of understanding how the funding is flowing. So this is really to address baseline data that just isn't available at this moment.

Next slide, please. So action step two, bottom line, barring any stipulations or specific requirements in the legislative language, the work group is propose that go all ppa's should be jointly required to the nofo's and David referenced the work underway in the whole government approach to health equity and this particular document is very specific recommendations regarding equity assessments and the disparity impact statements and the language in the guidance that hhs is -- has developed is really strong encouragement.

These are examples. The working group has taken it one step forward. That's an important floor and we know that the staff are committed to implementing peace -- pieces of the hhs guidance. The work group is directing the cdc to ensure all ppa's, all the projects, programs and activities begin to jointly create and implement a publicly accessible policy document for applicants and grantees responding to the cdc notice of funding opportunities, the nofo's, that detail the requirements for how health equity needs to be integrated into the processes and approaches for new or continuing applications. The working group went further and is recommending that there are also specific elements within that guidance for notice for funding opportunities, specifically if you're interested, I think it was appendix eight that outlines more details about the equity assessments and also requiring the disparity impact statements as a condition of funding and we know this would be new and goes beyond the strong encouragement of the hhs

but again, in order for this to address the long standing inequities and structural barriers, the working group felt pretty sure about making sure that this is required across the board. And not optional and what we did learn through our conversations with the cdc subject matter experts is that there does appear to be quite a bit of latitude and flexibility at the programmatic level to identify and to craft eligibility criteria for grantees and that we can get into discussions about why maybe traditionally it's flowed to the stlts but we think they should double efforts to revisit their internal processes around the nofa's and it would be consistent with work that's already underway with hhs. Next slide, please. The third action step really drills down to the entire life cycle of the nofo's in that there should be more intentional efforts to develop equitable systems from the very beginning to the end so post awards. So from the planning and development to the selection and post award support. In this action step, we'll see the work group is suggesting that all programs should be required to first engage community partners at the early stages of conceptualizing new funding opportunities to make sure they're more credible, relevant nofo's in addressing the true community needs that have been identified but those most approximate to the health EN I can -- inequities. Criteria that takes into equity factors or considerations. Looking at the evidence and the responses of true authentic community engagement, project budgets that reflect compensation for the participation and the leadership that are provided by individuals who lived experience. So really going beyond just inviting them to be part of the application process but as David mentioned, providing the agency and autonomy for them to be in decision making tables. Third, to improve the systems for strengthening and improving the accessibility of the technical assistance offered to the cbo's in the pre and post award phases and we did get great examples from our cdc presenters that shared how this was done. I think it was in Alaska with some of the tribal communities with Covid dollars. And they were able to do this during the pandemic so we want to see more of that pre and post award support to cbo's. Next to develop webinars and other resources that are responsive to language, accessibility and technical issues, including things like access to broad band, ensuring that the resources have screen reader compatibility. We heard from the hew members this often presents challenges for cbo's in developing successful applications and finally, the work group is suggesting that cdc provide longer application submission time lines to ensure meaningful opportunities to engage community partners in planning and development and this might open up more opportunities for diverse group of cbo's to participate in submitting applications given how we know having responded to many nofo's in the past, how complicated it is to make sure that all the different puzzle pieces are pulled together in a way that actually allows for and creates opportunities for community members to be part of the process. So those are the highlights from action step threethree. Final action step, nothing has changed. We included this from the first draft of the recommendations that -- and this speaks to an interest in workforce development and the facilitating peer to peer learning within the cdc. cdc should strengthen project SFSH engagement by developing or redesigning training materials that elevate ways to lift up equitable grant making and really emphasizing the important role that project officers play and try to shift from the mindset of being subject matter experts or specialists or people who are working amid ministry to try to get the finding

out to the mindset of coalition builders and thought partners to communities on the ground. We included this back into the proposed action steps that we're presenting to you this morning.

So next slide. I think this is where we'll open it up to discussion.

>> Comments or questions on this, Jill?

>> So my previous role was in this director of public health laboratory and if I was in that role again, one thing that I would do differently is to make the rules of the health department more porous. Labs are bureaucratic boxes, if you like, and I think that the laboratory test technology now is much more amenable to field work, to community based sites to going into the home and I think that cdc in its funding opportunities ought to allow a certain amount of the funding to promoting the pilot projects. You know, I think hov testing has some important lessons for how testing in the community can be much more approachable, less bureaucratic, more amenable to community characteristics, if you like. I don't think public health labs will ever go away.

There's an incredible role for them. But I do think that technology, the scientific technology, the platforms, while they're not perfect yet, do provide a valuable way of getting into the community more and making testing more approachable to more vulnerable communities so just a comment.

>> Thanks. Let me just make it clear that the cdc colleagues that are sitting around the table, although this is an issue up for a vote, are welcome to ask questions or provide comments as well. Josh?

>> Two questions. You said make the walls more porous for the lab, you were speaking figuratively, not literally.

>> We don't want leaky labs.

Communication should be much easier.

>> Got it.

>> We should reaching out to communities which I did not do.

Now the pandemic was crazy but I should have done that.

>> I'm learning on the lab work.

I wanted to check in. Second question is for David and Monica. The -- I think it's an interesting question whether the primary relationship should be cdc and local community based organizations or it should be the local. I don't know whether the group discussed that, whether there's something to say beyond there should be a little bit of both. In my view as a former local and state health official is it's really important for local and state health departments to be working with community organizations and that's why my previous comment was not so much

about ensuring the cdc grants give money directly to community based organizations but the capacity.

Your recommendation was for the local and state health departments to have the capacity to do that. That grant is for local and state health departments. But do they have the capacity to do that? A lot of them don't because of underfunding. I think the evaluation process could be really valuable. You know, if there were expectations for what could be done but my bias would probably be that cdc should be giving money to local and state health departments with expectations there be community partnerships and capacity at the local level so if you don't have a situation, and I've seen this where it's very confusing for a local organization whether they're oriented to the cdc, to the local health department, state department and it's not like a really community based effort overall.

>> We did talk about this some and I share your bias having been at both the local and the state public health agency. I know this might not be what you wanted to hear because you said it as an either/or. We saw it as both/and. We understood in our conversations with the cdc staff given who is an excellent presentation, by the way, in terms of the budgetary process and the compressed time frames and that often being the rationalrationale for going through the public health agencies and then having that funding flow to cbo's but I think we've seen examples throughout the country recently where there are state health agencies that have rejected funding. Critical, important funding like the example of Tennessee where the direct impact was going to be on people who rely on those services and so it wasn't an either SLAIB -- either/or. I think they should be building partnerships with communities on the ground but for the cdc to be more expansive, to allow programs to have opportunities to sort of stitch together different ways to get the funding in communities. So there's definitely a role across the whole enterprise for each type of organization to play and it wasn't -- there's no easy out, unfortunately.

>> I certainly agree with you where you don't have a local or state health department to do it but you're in a completely different world there. But there was a great piece by the former Mississippi health officer saying that his state didn't have the capacity to write grants, really, effectively.

Even agreements with local organizations. There's such a capacity question. There's the ideological issue. Anything cdc can do to build the capacity at the state and local level is going to pay off.

>> That's why we kept it pretty broad in terms of grants, contracts and then those cooperative agreements to the large membership organizations, right? So that is a role that the membership organizations play in terms of technical assistance and capacity building so it is -- I understand it's complex but there are many examples across the states as you pointed out, municipalities where there is a lot of sharing of best practices to work with community and really much more authentic ways so I hope that's helpful in terms of the discussion.

>> Two quick comments. Great discussion and having worked at the state and local level, my sense is there's a primary relationship with whoever your state or local health department is. One of the problems we had is surprisingly for an information agency like cdc, we don't have the information we need to know how bad this problem might be and where it's working and where it isn't so really calling for increased transparency in the sub grant resipents of the cdc fund to go assess where i going to communities and in fact, where it might not be going out to communities potentially because of the capacity issues, there's a sense that not as much money as would be best is getting out to the front lines and community based organizations. We really don't have that information yet on agency wide basis to know where that is a problem and where it might not be so that's one thing and that's in the first recommendation regarding a request for increased transparency so we can collectively assess the extent to -- which there is a problem and how best to fix it. Monica is going to smile here but while I have the floor, I think another key piece here is in the recommendation and you spoke to it a little bit, Josh, in some states that are potentially or localities that are potentially most in need may have the least capacity to actually get the work done. We are calling for in this for cdc to think carefully about the nature of its competitive applications.

Historically competitive has translated into more of an academic definition of how competition could work and speaking as a person who has worked in health departments that tended to be better funded than others, we were at an advantage. We had the capacity and expertise to write applications that actually were judged to be more competitive than others. What that means, though, is that where money is going is going to the places where the applications are best.

Not necessarily where that money can be best used. And so there is a bit of a historical legacy here and we would urge cdc to evaluate and correct as needed to establish criteria and its grants so that yes, you want money to be well used no matter where you send it but you actually want to make sure we're sending to the places that are most in need and to do some analyses, look at markers of health equity and health disparities across jurisdictions at the state, local and community level and make an assessment of realistically is the allocations of resources generally in proportion to need tore have we, through the competitive mechanism, inadvertently implemented a system where that's not happening as well as it might.

I'll get off my soap box.

>> We talked about that in terms of state and local capacity that oftentimes there's a bias to looking at the end product, the application and those that have the capacity to find development and grant writers. We had consultants we hired at the state and local depending on the particular nofo and so that creates a really unlevel playing field and I think that's what we were trying to address. And whether that's an unfair requirement or expectation of stlt agencies to impose the same requirements, for example, for $10,000 small grant to cbos that they would be they were awarded through a sub awardee process but I understand the concerns about capacity to sort of be more flexible. It is inconsistent.

>> I mean, if I could just say, this is just a big issue for the government and across beyond health, too, that's very interested in supporting community based work. These issues come up in other fields and I think there's probably systemic solutions that cdc could play an important role in finding.

>> Thanks. Any other comments?

If not, we'll do a little tag team. I will entertain a motion from committee member to take the task area two report, proposed action steps, and make them recommendations of the acd to cdc.

>> Moved.

>> Thanks.

>> second.

>> Thanks, octavio. Any further discussion? If not, let's go ahead and take a vote. All those in favor of the motion, please signify by saying aye or raising your hand.

>> aye.

>> Opposed? Any abstentions? If not, the motion passes unanimously. Congratulations and we will work to get these maybe with a few editorial changes to reflect the discussion today so that they can be approved and we will expect a report at the next acd meeting about cdc's perspective on these recommendations and how the agency is going to move forward.

Congratulations to this working group. Let's move on to the next agenda item which is a followup to this and it is a report from our new office of health equity.

She's on there. OK. I was desperately looking around for leandris. She's on the screen.

There you are. Dr. liburd, the acting director of office of health equity will talk to us about progress being made by that office.

>> thank you and good morning, everyone. I happen to be in Washington, D.C. today and unable to be with you in person but I would like to thank the health equity work group for all your thoughtful leadership and providing insight that would not be routinely available to the office of health equity. In the time that we've been working together through the health equity work group, we've been able to broaden our lens and recognize in real time opportunity to improve health outcomes so thank you. We deeply appreciate your expertise. This morning, I would like to provide a high level overview of the new office of health equity. We're actually in our first 100 days so if we could go to the next slide, please. This year marks another milestone in the cdc commitment to achieving health equity. In addition to the creation of the office of health equity, we celebrate 35 years since the initial establishment of an office of minority health.

The new office of health equity expands the scope, the influence and potential impact of the agency's efforts to reduce health disparities and health inequities by driving the embedding of health equity into all of cdc's work at every level of the organization. The new office of health equity is located in the immediate office of the director as shown on the cdc organizational chart on this slide and we'll work closely with sister offices within the immediate office of the director as well as with the national center institute and offices. So the office of health equity consists of four cross cutting components. The office of the director from which executive leadership, oversight and coordination will be managed along with driving accountability and assuring health equity is embedded at all levels of the agency, including focused efforts to align diversity, equity, inclusion and accessibility with critical skills for achieving health equity. Another office is the office of minority health which was first established in 1988 and codified in 2010 through the affordable care act. The office of minority health will continue to build a strong program of science, intervention, policy and systems change to reduce health disparities and health EN I can -- inequities and offices of color. Similar to the office of minority health, office of women AELS health at cdc was first established in 2002 and also codified in 2010 to advance and coordinate a comprehensive women's health agenda, including improving the health and well-being of girls and the director of that office is Dr. Pattie tucker. The newest office and still very much in formation is the office of equitable population health which takes an intersectional and inclusive approach to address the health inequities, the disproportionately impacted population groups such as people with disabilities, people who live in rural areas and people who identify as LBGTQ +.

Dr. Jeff hall is currently serving as both acting deputy director for the office of health equity. Let's go to the next slide. Our mission is that the office of health equity exists to ensure health equity is embedded in an all of public health approach to overcoming persistent health disparities and health inequities across a range of population groups that disproportionately experience poor health outcomes. And our vision is that all people have the opportunity to attain the highest level of health possible. Next slide. So the office of health equity has four overarching functions. One is the leadership function. The office takes an interdisciplinary, inclusive and coordinated approach to leadership in advancing the principles and practice of health equity across cdc's eco system. In terms of coordination, we will work across the immediate office of the director and with the cio's to establish and support standards for health equity, including embedding health equity into the agency's core capabilities and working CLABcollaboratively to achieve equity in cdc's culture, work force and workplace. In terms of collaboration, we will work closely with the cio's and external partners to develop, disseminate and where appropriate, recommend scaling best and promising health equity science, programs and communications practices. And lastly, we will implement strategies for attaining accountability or more important, fidelity to help equity standards, competencies and goals. These are the priorities for the office and some selected initiatives. We are in the process of developing a health equity strategy in organizational level equity metrics for success. We are also -- having a priority to create more equity in funding and in our nofo's and I would like to

add that over the course of the last year, through leadership with core, which many of you know is our agency's health equity and science strategy, we were able to create and incorporate health equity guidelines into our non research nofo template and we're pleased to share that for fiscal year 24 as our colleagues across the agency are writing nofo's, that they will be using the guidelines to inform the development much those nofo's.

We have a partnership priority.

I think very consistent with what's been shared by the health equity work group. We hope to increase community engagement with populations that experience health disparities. We also have a public health work force priority consistent with the agency's core capabilities and our intention is to build our own internal capacity to increase subject matter expertise in health equity, health equity science, health equity action and enterventions as well as policy within a work force and a workplace that is characterized by -- and I would even say experienced by diversity equity, inclusion, accessibility and belonging. And lastly, we have a priority around science and interventions to implement equitable community informed practices for advancing health equity in our research, surveillance programs, in our evaluation, methods as well as emergency response and preparedness and in the laboratory sciences. So in the right column, you see just some selected initiatives that we are pursuing and continuing to flush out. Some of them are established like Lewis and Ferguson fellowship and scholar programs. We are creating a template of trainings to help build capacity internally and we work very closely with our office of service and we'll work much more closely with the office of data and science and technology as well as the office of communication so we could go to the next slide. I wanted to mention some activities that we had over the last not quite 100 days. We had a power of partnership meeting where we actually, in two convenings, one in January that was virtual, the other just at the end of April where we brought people in to Atlanta and to cdc to talk about exactly, I think, what's been shared from the health equity work group which is how to strengthen connections between state and local health departments and community based organizations. We were first thinking about this how we could proactively prepare for whatever the next emergency is. And to really, in this time, between the next emergency, before the next one, really be focused and intentional about strengthening the connections. And this will continue to be a priority for the office and we were able to have 23 states represented. We had two local urban areas that were represented and a number of representatives from community based organizations so I think it's certainly a timely and critical conversation for us to be doing right now. We also had just last week our first -- we called it our core forum and we brought together the entire agency with examples of work that has been going on. We're now in year two of core. That's been focused on advancing health equity through the cio's, the deiab work that's going on as well as equal employment opportunity, understanding the rules and regulations, the laws that govern that and how they all work together and allow us to advance our work to reduce health disparities. We are in, as I mentioned, the 35th anniversary celebration of our now new office. But it builds upon a rich history and our theme is around baking health equity and we're getting recipes

from the cio's on what they're doing, what they input and how they implement, evaluate just their whole -- the way they pursue health equity, health equity science and partnership.

We'll be doing that for all this year. And, you know, we participated with the hhs office of minority health to celebrate national minority health month and as I mentioned earlier, we're in the process of standing up a health equity learning plan that will be available to the entire agency that people can select those courses that they need in order to build their capacity. We always invite people to connect with us. We have a quarterly health equity matters newsletter, we have a monthly health matters for women newsletter. We have a blog called conversations in equity that -- and we've had all of these resources, I think, for --

in some instances with health matters for women, more than a decade but our health equity matters and the conversations in health equity for about a decade. And we're very excited about our subscribership as well as the contributions that are made to the blog. When we first started, we were writing the blog and now the blog is coming from -- the contributions are coming from all parts of the agency. So with that, I think if we go to the next slide, thank you very much for your attention. As I said, we would like to think about the office's work continuing to stand it up, particularly in terms of our strategic plan, how it will impact both the work of the office as well as how we engage with the rest of the agency and with our external partners so certainly by the time of the next acd meeting, there will be lots more to share.

>> Thanks so much. Dr. liburd's presentation is open for presentation or discussion.

>> Thank you so much for this presentation. We're excited that you're building on 30 years of history. You're just out of the gate but I have to ask the question, how are you thinking about your api's key performance indicators? What are one or two things that will be different or new that you will track over time and show that you've made progress and achieved success?

>> Yeah. So some of that is still being determined through the creation of our health equity strategy but another priority that we have around funding, nofa's is to track the inclusion of health equity, the addressing of it in nofo's as they are being published and then we have a third priority around diversity, equity, inclusion, accessibility and through our work, we have a steering committee that has outlined a number of metrics as well as each of our cio's have made a number of commitments in terms of metrics and indicators that we will be monitoring, you know, over time. So we have identified some. There are more that we are crafting and will be vetting with other parts of the agency and then at some point they will be public.

>> Thank you.

>> while people are thinking, I've had the privilege of working at cdc in the past and the agency may have changed but given how much work all the different parts are trying to do, usually a specific area towards that responsibility, it's difficult to coordinate an agency-wide approach not because people don't want to do it but because they're busy doing whatever it is they're charged with doing. And talk a little bit, if you might, about the process that you have set up to

really try to create that agency-wide approach that you were talking about given that challenge of siloing and the fact that people are already running under 20 miles an hour to get their day work done.

>> I would start by saying that I use the core as an organizing framework where we have commitments of more than 1 # 60 goals that have come from our cio's. We do twice a year what we call an interactive dialogue session where we bring cio's together. We talk through their progress, their challenges, you know, what they need to do next in order to continue to move this work forward. And each of the cio's have designated what we call a core liaison and this is a person who meets with the core leadership team on a periodic basis. That's one way that we're starting with coordination. We also have, since 2018, what's called a health equity leadership network which also brings together people from around the agency who have responsibility for health equity within their cio and they meet monthly as well and what we're working to do now is to elevate that group and further empower it to be able to represent what's going on in their cio kind of broadly as well as as we are putting forward our health equity standards that we have defined as principles. You know, how we can use these networks to be able to better coordinate as well as to know. There's so much work going on and we discovered last week with the three days of the core forum just how much health equity focused work is going on around cdc and so I'm sure like we have some core data system where we capture progress and milestones and success stories. So it is a big list but I think we're in a good place to refine that and to continue to move that forward.

>> octavio?

>> Thank you for your presentation. It was excellent.

A big lift as everyone is acknowledging. And more, I guess, tied to David's question just to think about up rootization of the new office, a year from now, what would you like it to look like? What will you have accomplished by then within the next, say, 12 months?

>> So a year from now I would like to see the office sufficiently staffed so that we can pursue with confidence the commitment we will make through our health equity strategy as well as the commitments that we have already made in terms of priorities and how we want to work with the cio's and so a year from now, I would want us to be able to have documented evidence, if you will, of progress toward those objectives that we have outlined. I would like to see strong STRUSHGs within the cio's that support health equity. We have like some centers that have created positions where they have senior advisers for health equity or socio directors for health equity and that people in those positions feel that they have influence and connection across the cio and that they're not operating in a vacuum. I would also want to see improvements that are reported to us about the organizational culture and people's sense of feeling included and their perspectives on being engaged and the data of the agency. I think it's a combination of really capturing quantitatively progress towards the objectives and goals

outlined in our strategy as well as getting KWAULtative feedback from staff how they perceive health equity advancing within their organizations.

>> I look forward to those accomplishments and that reporting.

>> Absolutely. Absolutely.

>> Thanks. We appreciate you joining us from D.C. and we look forward to hearing from you both and during our next meeting as well.

>> Thank you.

>> We're going to take a break until 10:00 past the hour.

Please reconvene promptly then for the discussion on readiness and response. Thank you so much.

>> Let's go ahead and get started in about one minute.

Let's go ahead and get started.

Great morning session. We're going to have now a presentation by Dr. Ten -- Dr. Henry walke and some of the activities cdc has been participating in to improve the readiness and response abilities. Over to you, henry. Thanks for being here today.

>> Thank you and thanks for having me today. I look forward to the conversation. So I'm going to go over a few activities of what we're doing within the agency to strengthen our emergency and readiness response capabilities. I also wanted to share O.R. submitted a proposal that includes strategic mechanisms in reference to the conversations that were held earlier this morning and really state, local and community partner engagement. So I'm the director of the cdc office of readiness and response or orr and let me go to the next slide.

Thanks. And so our office, new office, is committed to ensure that go cdc strengthens --

ensuring that the cdc strengthens the response rapidly. I want to talk about a couple of activities to achieve our goals and I'll talk about our strategic direction and I'm happy to take questions around the office and at the end as well. Is let's go on the --

before we go, the two things I want to talk mostly about is the graduated response framework which really focuses on an approach, holistic approach, to strengthening our structures within the cdc to respond. And the second thing I wanted to talk about, spend a significant amount of

time on is the ready responder program that really focuses on our most relevant resource here at cdc, our work force. Next slide. So -- and the next. OK. So in orr we're responsible for implementing cdc's graduated response framework or the grf. We're ENaged in response every day as all of you know, working alongside the state and local partners and most of these responses are small and limited in scope but some responses escalate and require more resources and staff to manage them so how do address those levels of -- different levels of response within the agency and do that in a standardized manner? So we used this graduated response framework which enables our staff to scale public health response operations across multiple types of responses within our structure and also allowing for a smooth and fast transition between the levels so we would move from a program level response to a senior level response to an agency wide response and in a standardized way. We have a concept of operations as a blueprint for a multi level response management and it's base documents and annexes to provide the criteria within the staff of cdc and operationalizing and implementing our response strategy. So for example, the conops will include a wide range of topics such as roles and responsibilities in our response, data management and analysis in a response, evaluation and response operations and communication and best practices for scientific response functions. Now, this seems a little dry and a little administrative but incredibly important because in my experience across multiple responses, depending on the type of response, whether it's ebola, 2014, zika or Covid or ebola drc, how we responsibility historically is based on the program in which -- that's attached to that pathogen so we didn't have a standardized approach of how we would stand up an ims structure and rules and responsibilities so this graduated response framework is basically laying out the rules of how we would initiate a response from a program level to a senior level and then to an agency-wide level. Let's go to the next slide. So just to give you a graphic, here we see elements of a graduated response operations at different levels and in red we can see an example of a program-led response so these are routine or limited public health incidents managed by the division, branch or team within the cdc and that team of branch has the scientific technical expertise and capacity to initiate and manage the response with state and local partners on their own. So programs have to do some prioritization within their program to respond but they basically can take care of the response. And they sometimes use an incident management system and sometimes not and we, within orr, have the division of the emergency operations and we would provide some support to this program as they would need, for example, they were going to set up an incident management system, we might provide a chief of staff for them and help them with basic travel and logistics for standing up a response. We see the Ohio train derailment and the train derailment that occurred in east Palestine in Ohio this past February.

That was a center-led response at some point and now has been moved back down to a program-led response. But when the needs exceed the program's response, we would have a center led response. This is where you have a branch or a team that's leading a program, like a foodborne outbreak or a hepatitis outbreak and the outbreak is expanding across multiple

jurisdictions and there's not enough staffing or resources for the program to HAJSDZ. Then the center would step in across multiple divisions and help support that response with resources and staffing, for example. Again, we within the division of emergency operations or orr would help the center, help stand up the response of the center so an example here is the 2023 response to the new guinea and Tanzania outbreak and it's co-led by the global health center and national service for infectious diseases and recently, we had a team of about 15 to 20 people over the last couple of months and we're pulling some of that staff back now and actually, we're sort of at the end of that particular outbreak. So special pathogens was leading that at a program level that required a bit more assistance and multiple countries involved and then we escalated that up to a center-led response. Then an agency-wide response is basically when the response exceeds the capacity of any one center, we need to pull in the whole agency really to help. And we would activate staff from across the agency, escalate experts, units, programs from everywhere from environmental health to our maternal and child health and an example that obviously is Covid and another example would be our mpox response as well where we escalated quickly as the resources and staffing needs escalated as well. So next slide. So just want to make the point regardless of what level of response we're at, we're still responding. Decisions on the level of the response, the use of the incident management structure and support from our emergency operations center are made according to the needs and priorities dictated by the incident itself. We're also strengthening the partnerships with stlt health departments and positioning liaison officers in all the responses as a consistent entry point for state, territorial, local and tribal partners. So the grf really, again, is a framework in which we are standardizing our responses across the whole agency so that any one program or any one center or all agency response, we have sort of a standard operating way of how we support a response. This is actually -- I'm actually quite excited about this and it has implications on data, for example, how we manage data in response. In the past we've had different programs with different types of surveillance systems, whether it was vector born or another particular disease and that was started at the program level that might lead into a center-wide response and an agency response so we're trying to set the standards, set the procedures early on when there's the initial response instead as we escalate, we can use similar systems. Let's go to the next slide. The other thing we're doing is focusing our staff and we launched the cdc ready responder program in December of 2022, really building on lessons learned and incorporating input how to strengthen our emergency response staffing capabilities.

So the idea of the cdc ready responder program is that we're shifting the agency away from a long standing time and very labor intensive voluntary approach to response staffing to centralizing the staffing activities underneath one program and the staffing activity or cdc ready responders organized under a series of cadres, staff are selected to ensure we can respond to multiple events, public health events as needed. So we want to identify the right staff with the right time and we're trained ahead of emergencies and ready to respond when and where they're needed. Let's go to the next slide. So we're expanding a pool of qualified, diverse and

available responders. And we're training staff to enhance their readiness and response skills and here, I want to emphasize we already recruit and hire incredibly qualified people here at cdc so we're not training laboratory scientists to be laboratory scientists. We're ordering people to the emergency center and the response so we're recruiting people and then tracking the availabilities and when we get into a response, we can more efficiently for that particular event. These are some of the responder cadres. They're like buckets of functions. Talk about looking at a number of different events we responded to over the last decade or so. We started with these buckets of people related to communication response leadership, deputy im's, instant managers, for example, operation support for the logistics trying to get people, health equity and our health I can quit focus within responses and here we're recruiting people around the agency to fill these particular roles in a response and so we preidentified people who can take on particular leadership roles and we put them in these very cadres so we identify particular people who have skills and global migration, for example, and we put them in these particular roles. We're also building up over the next year cadres related to the behavior science, data analytics, data prevention and control, partnerships, all the key activities that we would do in any large response. So we have these buckets of these cadres of people who have the requisite experience and skills.

We give them some training, orientation to how to fit within an ims structure and then we --

once we have them rostered and we get into a large response, then we can look at their availability and we have the ability now within our systems to say, OK. A thousand people who are in all the cadres, we're -- here's a Covid response.

Here's the monkey pox response.

We need 15 epidemiologists, we can reach across the cdc and say these folks are in the epidemiology cadre and we not only need 15 epidemiologists, we need them to speak French. We have that information in a data set. They're prequalifequalified, prerostered and then we just deploy. Versus the alternative like in the past. Me calling up 12 people that I know who happen to speak French and have some experience in saying, can you deploy tomorrow or next week? We have a much more systematic structured system than we've ever had in the past. Let's go to the next slide. So we're pretty energized by this process. If you look at the last 15 after action reports related to cdc responses, staffing of our response will be number --

will be problem number one, two and three. So we really needed to find a way to organize ourselves and so we developed the cdc ready responder. A number of states have done this and I just want to acknowledge that. So it's cdc's time and we launched this in December. We probably have a thousand people enrolled, trained in cadres by the end of September 30 and our goal for fy24 would be 3,000 and eventually our goal would be to enroll most everyone at cdc if their functions allow into a cadre. So the idea would be that if you enter the halls of cdc, then you're a responder. You should see yourself as a responder. In the past it's been other duties as assigned so people would rotate on the response and then try to do the home job and

the new job and they can only come on the response for three weeks because there's other responsibilities.

We're really trying to emphasize that we're all responders. We all need to be trained. We all need to understand what the roles and responds are in the instant management system and then when we call upon you, you have the T-shirt. You're a responder. The expectation is that you will respond. For new employees as well, in our position descriptions, we are pulling in the response elements. It's clear when we recruit people and hire them, the response is part of what they do. Let me move to the next slide.Ly OK. I just wanted to spend a couple of minutes on some Congressional updates. And two of them, one is -- let's go to the next slide. So as most of you probably are familiar, the pandemic andal hazards preparedness act, pahpaia was in response to September 11 and the anthrax attacks in 2001. And its goal was to ensure the country is better prepared to detect prevented respond to public health threats and pahpaia is of particular importance to cdc and orr because it provides the framework for public health emergency preparedness agreement that funds 50 states, four cities and eight U.S.

territories. So pahpaia has played a critical role in our response to multiple emergencies, including h1n1, ebola outbreak and Covid 19 in 2020. So as this slide shows, pahpaia is authorized twice and due for reauthorization again in 2023 and our hhs and cdc's current reposals include expanded labor as well as flexible public health work force solutions so we can bring on people quick until a response that would include direct hire authority, danger pay and some flexibilities around pay in general. Next slide. Just wanted to remind everyone in the fy24 presidential budget included $20 billion of mandatory funding, dispersed over five years to prepare for pandemics and other biological threats and this funding supports priorities that have been outlined in the 2021 American pandemic preparedness plan and the 2022 national defense strategy or nds and so among those, among that funding, about $6.1 billion would go to cdc to modernize and build laboratory capacity, strengthen data systems and enhance global disease by security efforts and support capabilities for monitoring and evaluating vaccine and medical counter measures' safety and effectiveness. And for orr from the $6.1 billion, orr would administer about $943 million which is a $38 million increase from fy23 for domestic preparedness and that $38 million was a little misleading because it reflects the protection of the protect or what's called hss to the cdc.

I'm going to stop here in terms of fy24, certainly in some of our orr priorities, as we internally reorganize and refocus after the Covid pandemic, we really want to focus on readiness and response science and the science of actually how you stand up an ims structure. We obviously noted some areas around community engagement, behavioral science and that's also an area that we're extremely interested in health equity. In response we know there's populations that are disproportionately affected in every response so it's similar to a conversation that you had earlier today. How do we work with state and local health departments, community based organizations, identify the communities at risk and ensure that we can mitigate the impact of

any public health event when we get into an response? That's the area that we're extremely interested in. Then you saw with the cdc ready responder internally in the grf, global --

or graduated response framework, we're really trying to professionalize the way we're approaching responses and standardize our approach and try to bring in the whole agency, talents and skills to bear against any large public health event. I'll stop there.

>> Thanks, henry. That was a great presentation. We'll open up for discussion. Just before we do that, though, I would like to say hello and recognize Dr. Meadows who has been able to join us. We would like to give her an opportunity to introduce herself and declare a conflict of interest.

>> Good morning or good afternoon depending on your time frame. I'm Rhonda medows and I have no conflicts to declare.

Thank you.

>> Thanks so much. Jill?

>> Thank you for that presentation. Going back to early 2020 which none of us want to do, one of the -- issues that we saw was internal communication at cdc and that people who were part of the response reported to the supervisors they did not report up the chain of command of the incident management system and I think it's really important for you to make sure that understanding is there. I mean, I love we're all responders. We are all responders but the chain of command is different in an emergency situation and I think it's important to -- for everybody to recognize that.

>> Thanks for bringing up that issue. I couldn't agree more. I mean, I have a lot of intense emotion around this piece because we -- you know, as the incident manager for about 14 months during Covid, there were times, certainly, where we did not speak with one voice. We weren't organized, you know, underneath a unified incident management system. We had a structure and we learned from those lessons and there was a lot of spirited, I would say, conversations in the hallways around what was working and what didn't and I think this is getting to break down the silos at cdc and this concept, at least of that in an emergency, we are one cdc. We work for cdc and we are supporting the mission of cdc and if the director said this is the number one priority of our agency, that is the number one priority and we're all moving together. In one structure to make it work.

So I have seen this evolve over Covid and I think we're in a much better position, certainly with all the initiatives and are moving forward to really have a more cohesive response. You'll see in the graduated response framework, I could just talk so long about this, probably things that I shouldn't, but we want to provide a lot of support early on in a program level response because the way the structure is at the program level or at the center level is extremely important because of how we're pulling in data from the states, case investigation forms, for example, how we're staffing and certain positions, chief of staffing were the most critical, we want to

have the best practices early on so then we move to that big response in a hurry and bring all of the cdc in that we start on the right foot. We have the best practices in emergency management at the very beginning.

>> I think for people who are, I'll say, not senior level of the organization, their initial response is to go to the supervisor. It's a different management system and the senior people need to know the bad things as well as the good things. You know, most people just want to tell, hey, this is working, that's working but they need to know what's not working and that's not -- they have to understand that that's important to know and it doesn't reflect on it.

>> Thank you. Another piece is just trying to get everyone an understanding of what ims is and the goals and responsibilities but it's also about bringing the best people and senior leader INTUZ a response and I'm looking at Karen over there. She knows that early on in the response, I was trying to bring in as many senior leaders as possible because we need good management in a response. It's chaotic and we need, you know, senior people in cdc helping to manage the response and we also need senior leaders in the response so they understand some of the challenges and bring in their own people and help and see how important actually that response experience is.

>> Congratulations. I think this approach to incident management is going to fundamentally change what cdc does. My question relates to how do you relate to the rest of hhs, the rest of federal government and beyond, states, locals, private sector, et cetera? A big question about how you're starting to think about what will be different next time when barda is doing something, when onc has opportunities, when so many others beyond the cdc, how is orr going to look differently?

>> Thanks. Thank you for the question. One of the responsibilities, one of the if you thinks within the office of readiness and response is really the inner department coordination, the agency coordination around preparedness and response and what does that mean? We have a very tight coordination with asper within the department and with barda and within nih related to response activities so that hasn't always been the case in the past and so with KFD and really need to collaborate more and with the Covid pandemic being an all U.S. government response, we have worked on our policies, our collaborations within the department to set up these disaster leadership group so sync across all the activities and if we get into a large response, we move into a FEMA-led response. And of course, depending on the administration, some of that is a bit more smooth than others but that would be the idea that would then, you know, cdc has a response and we feed into the secretary's operation system at hhs that feeds into an overall FEMA coordinated response for a very large event. For state and locals, this is an area that I believe and I pitch my team that we're going to work on more is how our emergency operations center actually connects back to state emergency operations centers. There's a number of state and -- states in the country and cities who have very strong emergency management operations and a very skilled work force and they are managing within their own states various disasters or responses and we need to do more to sync with their emergency

management work force and operations at cdc. We should sync with their public health emergency operations more than we're doing now. That's an area that we hope to make some gains in, in the next couple of years or in the next year or so.

But within our agency piece, a lot of challenges, a lot of lessons learned. I feel like we're in a better space and I would say for at least readiness and response, orr is the lead for that engagement with the department and the inner agency space.

>> Yes. Thanks. Yeah. I first want to say, henry, I think that this is a great conceptual framework and not only that it makes sense, you know, in terms of emergency response but I think that something is communicable to people in the agency. They understand what's going on at any given time and what level is being mobilized. I think it's very helpful. I do want to somewhat agree with Jill that I think there's still implementation challenges and what I didn't hear and I think it's going to be really important, will your office or somebody have the authority to require cdc people to participate in drills and drills that really, you know, test to the limit the ability for people to overnight change the mode of work from I'm working in my chain of command to I'm working as part of an incident command structure and an after action process that is stringent enough that you identify the problems and -- because every time you have new people and right now you have people who may remember what happened three years ago but in a year or so you won't have a lot of those people around and I think that people are often very confident that they understand a plan and that it's just trivial and kind of even stupid, you know, to expect them to go beyond just expanding it and it's not until you put people through a drill that there's problems and learn from it and it makes them better at an actual response.

>> Thanks for that comment and again, I just want to agree and maybe foot stomp that. As we go through just for exercises, as we think about our work with moving forward and all the issues that have been identified and actions, priority actions that we're taking to try to deal with them, some of them are related to response, for example, how we stand up scientific clearance or how do we staff any particular response. As we put in new policies and procedures, we are planning and have done a series of exercises to test them to say, OK. We have a new protocol and scientific clearance. Let's see if it works or not or we have a new way of integrating data from state and locals and to a common operating picture, let's have a scenario based exercise to a series of short micro exercises to look at how our new policies and procedures are working as well as more functional, multi day exercises around a particular scenario where we might pull in a number of those different capables. To your point, how do we engage the staff in these types of exercises? So a couple of things. One is at a very high level, an expectation in, you know, executive performance plans or at a very performance plans, you know, from supervisors is that expectation that staff that you supervise will participate in exercises or public health responses during fy24, whatever the performance is. So I think measuring the supervisors' approval of their staff to engage in staff engagement across the agency, in exercises or responses, is an important piece of that.

Obviously there's the -- you have to do -- participate.

There's that piece. The expectation among senior leaders and supervisors is that your people will participate in all public health responses as needed as the agency needs or exercises and then there's that bottom up piece saying participating in responses is just wonderful and here's x, y and z why because of all the people you need across cdc, all the career responsibilities, to fill roles and there's a bit of that as well, especially for junior staff who aren't afraid of coming into a response to help them orient and like what are the advantages of actually being in a response? The other piece of this which you didn't comment on but I'll bring up here is when we get into a response, people at cdc or programs would say, you know, what we're doing is critical and I can't send people to the response because what we're doing at this moment is critical and therefore, we have to keep that moving and sorry. Talk to me next year. And so if you look at teams and branches and divisions and centers, is everybody critical? We've asked for senior leaders and supervisors to say, OK. Not only are we going to track your employees into the cdc ready responder, we're also going to track, do you ever a plan? A continuity of operations plan?

Have you prioritized what activities in 2024 are critical that need to be continued no matter what? When people say I can't come because what we're doing is too critical at the moment, we're going to ask them, is that in the plan? Take a look at that.

There's management pieces here we can use to ensure that we have engagement from around the agency.

>> I think you're right. I think you can make -- I mean, if I can't do cardio respiratory life support without getting training and practicing that, you know, why should I be able to do response for an entire community, state or country, right? So I mean, maybe that's a way to help to explain that but, you know, as we saw with Covid, people got sucked into this who had never thought of themselves as being on the front line of being in a response, right? I'm in a lab developing pcr's or something like that so at all levels, there's some level of engagement that people need to be prepared to participate in.

You don't know what it's going to be. Next one may not be a virus. It might be like a massive train wreck or something.

>> Just to comment again, 100% agree and burnout is real, especially when you use the same core group of people who respond to everything. People get burned out over multiple months and we have 12,000 plus people at cdc.

We need to use the whole agency.

I also want to call out to state and local public health because those folks are on the front line, didn't have the resources and staffing that cdc does and they were on 24/7 so we're seeing that burnout in terms of the number of people who were actually leaving public health with the state and local health departments so we really want to make sure at cdc that we are distributing the response if you thinks across the whole agency.

>> One last comment from octoctavio.

>> Thank you. Great presentation. My question is in the vain of my colleagues here but first, I think eloquent framework and two, what do you find is the greatest resistance?

Thinking about from organizational MAIFRal standpoint and you kind of are answering that question as you were talking to Lynn. Second to that is any concerns or do you see challenges as the leadership change with Dr. Walensky stepping down?

>> Yeah. Thank you. In terms of challenges, it's -- from at least the way I see it from the staffing standpoint is someone who has spent almost 22 years at cdc, there's a real misunderstanding between sort of day-to-day, cdc work, what we do and whatever program-lead responses to these very large responses like ebola or Covid and there's a misunderstanding about the role of emergency management and confusion about what emergency management is and how it can help, you know, subject matter experts in a response to organize and efficiently respond. People say I don't want to go to the response. This is chaotic. I don't understand what's going on. I would never go to the eoc.

I don't understand the language.

I don't understand the lingo. It feels a little too -- too much chain of command, has a sense of not public health, more rigid in terms of roles and responsibilities. And I think there's a translation between --

and that's one of the reasons I'm really interested in my current job of someone who has been on the other side. I see the need, really, for emergency management and the need to organize ourselves in a really good efficient way based on some principles that are well known, actually, how we respond to natural disasters, for example.

So FEMA has a lot to teach us as a public health agency of how we mobilize ourselves and organize ourselves for a particular response. So I think that's one of the -- a bill CHAG ENG is trying to -- there's sort of two cultures of sort of a scientific culture of cdc and here's how we do things versus an emergency management to fill a role. It's not about you're an expert in the subject matter expert. That may not be the subject manager.

What we need is the incident manager potentially not someone who is the deep expertise on that particular pathogen. What we need is someone who can actually manage a response who can organize the logistics and who can manage all the personalities and keep things moving along. So I think that's a big challenge. And I would say with -- in terms of -- I think we have changed fundamentally as an agency post Covid and moving forward to Dr. Walensky's credit gives us a framework in which to change and in which to make progress. And I don't see that changing after our director leaves. There's a lot of hope and reaction around the agency.

>> Great. Wow. Thank you so much for that presentation and for your leadership. It's great to see the steps that you're proposing to take and have already taken to improve response and I

think adjusting and perhaps even fixing some of the problems we've seen in the past so thank you for that. And we're now on lunch break. We have 45 minutes. We're a little bit behind but not a whole lot so let's do about 25 to the hour to resume with our global health presentation. Thank you all.

This is a test for captioning.

>> Let's take our seats on we can start. And looking around the table, I see octavio, Jill, Monica, myself, neira, crystal, Rachel, Lynn and on the zoom we have Rhonda so we have a quorum.

Welcome back after that delicious lunch. And really happy to have with us Dr. Howard zucker, the director for global health. And we'll look at global health. You're on.

>> Thank you very much. And I am new to cdc. And just a little background, Dr. Walensky wanted to bring a lot of the global health efforts across the agency together and created the deputy director position for global health to address this and after the pandemic, we recognized how much global health is so central to everything that we do not only overseas but also in the United States and so that is the role and I would like to think Dr. Denise nesio. With that, next slide. Thank you. The --

actually one more slide after that. I want to talk about global health security but one more slide. Outbreaks and pandemics have driven health --

go back one slide, please. Thank you. They have parked political conflict, they've gridlocked international trade and they've sunk economies and redrawn maps.

Disease outbreaks have undermined the security and well-being of every generation, every community, every civilization and they will continue to shape history. So a little history. In early 542, the plague struck. At that time the city was the capital of all of eastern Roman empire which was led by the emporor, Justinian. It didn't burn out until 750 which is a long time, 200 plus years by which point there was an entirely new world order. Jumping to 1347 when the earliest quarantines were responded to the black death that skilled an estimated 25 million people in Europe and Asia between 1347 and 1352 and the word quarantine actually comes from the Italian word meaning 40 which refers to the practice of a 40-day quarantine.

The period of 40 days was chosen not for medical reasons but for scriptural ones. Jump forward 500 years, 1863, Lincoln's train ride to Gettysburg, he reportedly told his private secretary he felt dizzy and weak and nevertheless he gave that speech. Unbelievable memorial speech that

everyone can actually quote and taught to recite in public school. And then on the train ride back home, he developed a high fever, a widespread rash that morphed into smallpox lesions. He said to people when he got back to Washington, I have something to give everyone but no one wants it. Smallpox, an ancient virus, is estimated to have killed more than a billion people before eradication in the mid 20th century and then we have the outbreaks of hiv, aids, and Covid 19 that has shaped the social and political fabrics of you on world today and will have a lasting impact on the way of life. Outbreaks like these and others have defined some of the basic tenants of the cdc. Next slide. We've known for a long time that a health threat anywhere is a health threat everywhere. However, the degree of our investments in the global health infrastructure systems work force and programs that can help prevent and detect outbreaks in the early days remain insufficient. Population growth, rapid urbanization, DRUPTing the equilibrium of the global world. In today's interconnected world, a disease can be transported from isolated village to any major city in as little as 36 hours. The global m pox outbreaks in Tanzania are a recent example of how the risks of emerging infectious diseases are increasing daily and how global systems remain ill equipped to prevent and KWAN the threats. This is where cdc steps in. cdc is seeking to change this by working with countries and parliaments to invest in laboratories, data, surveillance and communications infrastructure for timely and effective detection, for response and prevention of health threats. Next slide.

cdc's global programs address more than 400 DEEZ does health threats and conditions that are major causes of death, disease and disability. cdc has a history of more than 70 years of global public health excellence and a record of trailblazing science and evidence based decision making. cdc's work force includes scientists and seasonal technical experts who lead the global efforts to detect, prevent, control and treat a broad range of diseases, respond to health emergencies and strengthen public health systems. cdc's public health leadership influences the advancement of global science and practice. cdc collaborates with MIN industries of health in more than over 60 countries and other organizations including U.N. we know about W.H.O. but also UNICEF and many other organizations. And also working with non governmental organizations to address and solve major health issues such as Covid 19, influenza, hiv, zoonotic diseases and vaccine preventible diseases which seem to be on the rise. Expertise and technical exchange with partner countries and other global institutions bolstered the U.S.

as a global leader. Given the agency's broad global presence, and depth of partner collaboration, cdc staff are at the forefront of international relations as we advance and promote health security, enhance health equity and respond as we've heard this morning. As we look at security efforts before and doctor the pandemic, cdc is recognizing that these diseases know no borders and cross border collaboration is critical. In addition to establishing over 60 country oftenses worldwide in 2020, cdc has established four regional offices, one in eastern Europe in Georgia, another one is the middle east north Africa, south America, that office is in Brazil, southeast IESH -- Asia in Vietnam and we'll add two more regional offices, one in the Caribbean which will be based in Panama and one east at Asia Pacific based in Japan.

cdc's approach of establishing country and regional offices around the world advances security goals and maintains a comprehensive presence that allows us the flexibility to focus on the core capacity building efforts where they are most needed in order to address outbreaks, provide technical assistance and/or advance key programmatic objectives. Experts work alongside local and regional partners in all regions to provide unparalleled expertise, including data analytics, disease surround railance, laboratory systems, workforce development, emergency preparedness and outbreak spoons and we engage with foreign governments to address health challenges. In addition to increasing public health capacity, these partnerships serve as entry points for broader diplomatic engagement making the ongoing global work with and you can hear when henry was talking about our work we do across the globe as well. Next slide, please. Thief bit the FELT infrastructure for example, 73% of global centralized labs implemented the sars testing.

The cdc office supported vaccination efforts with assistance from the implementation partners. And in Uganda, our office funded Covid 19 vaccine outreach through the infectious disease institute and leveraged existing platforms to minister the Covid 19 vaccine.

Is has made an impact on how the disease was curtailed in other parts of the world. With additional resources include in the presence request for physical year 24, cdc will be able to modernize and build laboratory capacity and strengthen public health data systems, enhance global disease surveillance, bio safety and bio security efforts and support capabilities for monitoring and evaluating vaccine and safetiyness and effectiveness.

There's continued focus of investment on global health security. It's vital to improving health outcomes and recovery lost ground in global responses from hiv, polio, malaria, tropical diseases and numerous other health threats.

Everyone benefits when we have strong and equitable public health systems with a highly skilled work force. Since 1980, the cdc has trained more than 19,000 disease tee TEKTives in over 80 countries through the flagship field epidemiology program. The program is really truly a remarkable program.

Since 1980, cdc has partnered with the ministries of health in more than 80 countries to strengthen their work force through the program that's modelled after the eis program.

This on-the-job training in dozens of countries has allowed experts to track, contain and eliminate outbreaks before they become epidemics. In Nigeria, cdc office built offices to eradicate polio. And in Thailand, the United States cdc office identified and expanded existing flu research platforms to wall -- evaluate effectiveness for Covid 19. cdc is also engaged in improving health care quality at the global level, enabling the safe delivery of health care through eliminating the risk of infection. Since 2014, our international infection control program has worked to protect patients and health care personnel in more than 40 low and middle income countries across many geographic regions and has partnered with public and private organizations in the United States and around the world. Working close well partners in

countries, cdc supports development of sustainable infection prevention and control capacities, in health care systems. As you can see on the map here, cdc is rapidly responded to infectious disease outbreaks and health care settings, abroad such as Covid, ebola, mpox and so many others as well. In addition, this program supports monitoring and prevention of health care associated infections and the detection prevention and response to anti-motorcycle robe YAL resistance and health care globally. To prepare for the next emergency outbreak or pandemic, cdc can activate from a wide range of tools in the global tool kit to strengthen and support health system capacity in four essential areas. Expanding disease surveillance systems to quickly catch outbreaks before they spread broadly, strengthening laboratory networks to accurately diagnose diseases and identify pathogens, training, a skilled public health work force to contain outbreaks at their source and establishing emergency operation centers to coordinate response efforts across sectors when crises occur. Some of the programs are the cdc global disease detection operation center so this was established in 2007. It provides exchange for real time information by the United States international agencies and other countries, often being the first to alert the United States government about international outbreaks and the risk they pose to the American public. In others the cdc partnership with the national public health institutes and the program THA just mentioned which are the building blocks for country's health security and by extension to global health security. Now there's the new global leadership program which works around the world to help countries build public health capacity, prevent, detect and respond to disease threats at their source. And the last one I'll mention is the global joint external evaluation tool that assesses country's health security strengths and weaknesses, pinpointing the most urgent gaps in public health systems around the world and to date, more than 113 have been COMBEETed representing over half the United Nations member states. cdc experts have participated in over 60% of those conducted thus far global security agenda and making sure the implementation for the United States is working, directly with partners by directly working with partners, country governments to strengthen the public health systems and reduce the risk of infectious disease outbreaks so we recognize that the ability of countries to respond to health threats depends on the strength of their capacities in four core areas. Surveillance, laboratory systems, workforce development and emergency management and response. So focusing on the potential weak links in the core areas ensures that countries are well prepared to respond to disease threats wherever they might begin. So we leverage our partnerships with non governmental organizations, multi lateral organizations, private sector and other stake holders to support the security agenda and the mission of making sure we stop outbreaks globally to protect Americans locally and we do this by tracking and responding to disease threats, by training these disease detectives out there and by deploying the cdc respondents which we have out there right today all across the globe. Over the course of five years of the global health security agenda, all 17cdc supported countries have improved their capacity to prevent, detect and respond to infectious disease threats. We play an essential role in implementing programs internationally to support the U.S. government's national bio defense strategy which helps ensure that outbreaks are stopped before they land on our shores. Most effective and least expensive way to protect Americans from diseases and

other health threats that begin overseas is to stop them long before they journey towards us, causing social disruption in so many ways as we have seen. When countries work with cdc to develop sub national disease systems and bolster the health work force and act decisively in the face of outbreaks, we can prevent epidemics and they don't -- epidemics that don't happen are much less visible than those who do. It's easy to overlook the careful planning and swift strategic action that goes to keeping the world safe from infectious diseases that happen MIND -- behind-the-scenes. It's easy to lose sight of the progress we made but we can learn just as much from our successes as our failures. Take the containment of an influenza outbreak on a cruise ship in the south Pacific in 2009 or the containment of yellow fever in Brazil during the 2018-2019 seasons, the 2021 ebola outbreak in guinea that was declared over after six months and prevention of a cholera outbreak in spite of a regional outbreak that caused 109,000 cases and 3700 deaths across west Africa in 2021 #. These are just some of the epidemics that didn't happen. The stories that did not make the headlines. These failed epidemics are a testament to the power investing in preparedness and they demonstrate quite simply that preparedness works.

These EM -- epidemics that did not happen show that communication by determined leaders can find, can stop and prevent outbreaks. Next slide.

When we invest in people and systems in partnership with communities, we can stop the spread of disease and obviously save lives. More than 70% of the world remains underprepared to prevent, detect and respond to a public health emergency. When countries prepare consistently and act decisively, we can prevent epidemics. Every day around the world, public health experts are preventing epidemics and these smart investments improved health systems and better coordination and communication by determined leaders prevent outbreaks. The winds of preparedness and absence of epidemics are not always obvious and without clear metrics it's hard to quantify success and quantify investment.

It's a little bit about investments. Investments today will provide a healthier world tomorrow. Little effort is made to strengthen systems to prevent epidemics when we aren't staring one down. Covid 19 caused an economic shock three times worse than the 2008 financial crisis and caused the biggest blow to the U.S. economy since the great depression. The economic disruption caused by the Covid 19 pandemic is estimated to have cost the world more than $16 trillion. Many times more than the projected cost of preventing future pandemics according to a recent study. By one estimate, it would take just $124 billion the next five years to make the world better prepared for epidemics than pandemics.

Similarly, the U.S. federal government spent $4.6 trillion to respond to and recover from the Covid 19 pandemic. In Congress, a study from the commission in 2016 advised that increasing global expenditures on pandemic preparedness by $4.5 billion by year which is a negligible investment. We cannot afford to repeat our mistakes again. Covid 19 is the latest and most devastating crisis to underscore the need to shape a sustainably, funded preparedness to pass globally. Prioritizing a sustained focus commitment to global health security is vital to saving

lives using resources wisely and minimizing political and economic instability around the world. At its core, the cdc's work on global health security is the translation of investments into life saving actions through disease programs and cross sectors that impact health and communities where local and global are linked P.

We cannot build a safer, healthier world and achieve health security without health equity. To address the next public health threats and pressing issues facing the world, we must work together to solutions for all on a global scale. cdc embeds health equity into the design, the implementation and the evaluation of global programs and activities. Five pillars guide cdc's global public health work across the agency. Diverse partnerships, innovation, sustainability and health equity. cdc works to eliminate health disparities and achieve optimum health throughout all the pillars and more specifically, by addressing health equity to reach those in greatest need through global programs, research, tools and resources and leadership. The United States and the world are at a critical point in the fight to sustain the progress made in global health security and health equity. And cdc is committed to be a leader in both areas as they are interdependent. cdc will continue to work in communities near and far to build a world safe and secure from emerging and re-emerging health threats.

Diseases won't stop and neither can we. We will continue to do this by providing timely and effective response, by fostering a public health action oriented cdc committed to accountability, collaboration, communication, timeliness and equity. Building world class days A analytics, a diverse work force, state of the art laboratories, more effective response to outbreaks and expanding global health capacity and preparedness. cdc's global public health work embodies American values using both U.S.

knowledge and technical expertise and the knowledge and technical expertise of our global partners to protect and enhance health and likelihoods of the United States --

livelihoods in the United States and around the world. As I began with historical references, I will end with them as well.

History is written not only by men and women but also by microbes. Similar to Lincoln at Gettysburg, the lingering effects of the Spanish flu hindered woodrow Wilson's to effectively advocate for his 14 points at the end of the World War I. He was left bedridden to the flu in perhaps the middle of the most important negotiations in his life. Spanish flu killed one in 600,000 in the United States. When Thomas Jefferson wisely commented an attention to health should pay more attention than any other object, he would not imagine that his words would impact today as we look at Covid 19 and work to prevent future outbreaks of pandemic potential.

It took the pandemic to remind us the power microbes have over our lives. Very few phenomena have shaped our culture the way the outbreaks of infectious diseases have. If we learned anything about the pandemics and the outbreaks, the health of people in one corner of

the world is so linked to the health of millions around the world and that will remain true for centuries to come. Thank you.

>> Thank you. Open the floor to questions or comments for this presentation on global health. I think I'll lead off. There's no question that security is the key issue from a threat standpoint to the United States, it's probably the most immediate, one that I think enjoys considerable support and as you know, when you talk to many, if not most of ministers in low and middle income countries and ask them what their biggest concerns are, they generally say non communicable diseases. Africa has more untreated hypertension on that couldn't -- continent than any other continent and when you ask the ministers, you ask where to respond and they say communicable diseases. How is the cdc working to help countries with that emerging health threat in their countries as well.

>> This is something which we spoke about internally and I've heard about a lot which is --

you're right. These non communicable diseases, hypertension and diabetes and heart disease, cancer are really killing more people on a larger scale. I think the answer here really is that we need to have more partnership with some of the countries on this. We have to make sure it gets more attention and I think it's also working with some of the non governmental organizations that are very focused on this so hyper attention, we know that that's one of the areas which resolves to save lives is addressing and when we the foundation was here the other day, we were talking about other issues that had nothing to do with infectious diseases as well to I think getting the on the radar more will be helpful. Than there's funding. That's a tough one to tackle because I think that people don't recognize sometimes that controlling some of these non communicable diseases also -- overseas has impact on our lives here. If you end up with a country where people have chronic disease and their work force is compromised, all of a sudden you find that you have a country where they are no longer able to actually achieve the goals they want to achieve and that creates some pretty safe and secure. So I think we need to get more attention on that issue as well.

>> This is exactly what we hear every time we meet with ministers of health and one piece that we're seeing more and more because the country where we have a country presence or a regional presence, we don't just go by disease. The funding comes by disease but the programs take care of people. So even visiting like Kenya and India, even for the programs, they'll have part of the care to include hypertension, heart problems, really looking at the patient, looking at the person who are also being treated for hiv and addressing the other issues they have. This is also something that the ambassador talks about.

He's known for that and he's really talking how we use the resources that we have implemented to address those diseases and they don't want the money. They want technical support. They want to know how to better implement things so as Howard said, it's a challenge because money doesn't come for that but it doesn't mean that the countries and regions are not vocal in saying how to do that.

>> thank you. Josh and then Lynn.

>> Thank you for the presentation. I wonder how cdc thinks about its role working with countries versus multi lateral organizations, how do you partner in particular, how do you see the role of W.H.O.

and the relationship between the C.D.C. and W.H.O.?

>> I think there's two parts.

One is organizations that don't necessarily have the technical expertise but are out there in the field doing other things and funding and then those who are very -- I would say [Inaudible]

and others have technological expertise like the W.H.O. so I think there are organizations out there not living the technical expertise we bring and I think that requires a partnership. Sometimes the organizations that help fund others and fund programs and I think that's very important to achieve but there is something very special about the cdc because there are people here as we all know that understand issues at such a level and such a depth that's not matched and I will begin the example that we have people within the organization who actually, literally understand that disease, how it's transmitted, which kind of bat, you know, exactly where it is, what is the patterns and what part of what seasons do you see it. This is stuff that -- or information that's really a technical component that I don't think is matched by many other organizations. So we need to work with them on that issue.

Then comes the international orrings like W.H.O. and I think this is where we need to be in sync because -- and we have people over at W.H.O. and THE always turned to cdc for advice and THE expertise there as well and I think one of the strong presence between W.H.O. and cdc in the country, you can achieve a lot. It goes to the issue with Ecuador new guinea so W.H.O. and cdc works with them to achieve what's needed. I know there is an advantage of being in an organization where you're not one specific country but you're sort of a basically representing all countries and I think there's -- we need to work closely with organizations of that nature as W.H.O. in many ways so I hope that will move forward and continue and we have the world assembly in a couple of weeks and aim -- UM sure a lot of these challenges will be there.

>> I want to add because locally, like I said, we have a presence in 60 countries and four regions, we have almost like 2,000 people but 70% of them are local employee staff so cdc, we don't just want lots of people who go to countryd. We want to give that. So W.H.O. is critical. All the programs have people embedded in W.H.O. and locally also working with our new W.H.O. Another part that's important is to empower the local organizations because they also - - many local organizations are involved in that so that's another part that is very, very important for the impact.

>> Hi. Yeah. I was also interested in some of the issues around coordination and because I know we have also other agencies, aid and others that are in -- often in the same countries and that many times the global infectious disease outbreaks are accompanied with, you know, massive

humanitarian emergencies as well, whether it is hunger or even humanitarian crises that are created by the disease such as what we saw, certainly with ebola and I think with the creation of children who need sudden care and homes and all of that. It's not clear how all of that is coordinated.

Just seems like a multitude of U.S. agencies and others are involved and what is your role?

And for example, people who come in to do humanitarian work, are you involved with making sure that they themselves are protected and how do you do that?

>> So I think the -- couple of things. One is there's a create example of U.S. aid with their expertise in developing and that's where we have to dovetail with what they do to achieve the goals that we have. I guess is the question you're asking how to be sure there's safety in those who are there or safety for those in the community?

>> I mean the broader public health issues that accompany many of these larger epidemics where you not only have the disease to control but you have basically large humanitarian problems. Population dislocated by the epidemic, impacts on kids who aren't necessarily infected themselves but are losing their parents and then, you know, various other workers who are on scene, not just your workers who need to be protected. How do you deal with that? It's a bigger public issue.

>> It's a community issue is what we were talking about before. It's more about the whole community, it's about making sure the disease issue is addressed and I was talking about the earlier the other day that you have a disease that health system starts to fracture, society starts to fracture and get some civil unrest, you create a void, work force people start to leave and it's just a domino effect. One thing happens and everything starts to fall. So the key thing is at the beginning of this whole situation, you want to stop it and that's where the partnerships whether it's UNICEF, you can go down the whole list, is working together in country and as Denise was saying, working with the people in the country and the orrings in the country. I think one of the things we do very well and I think it's because we have country offices is that the cdc leadership in those countries are attune to the culture of that community and I think that that's very important. If you parachute in and leave, you're not aware of what some of those concerns are and I haven't spoken to many other country directors. We've said that it's really important for the community to trust you and to recognize that you understood t understand what their culture is. And even though there are criticisms about Covid in the United States from all the country directors I've spoken to, they were extremely appreciative what cdc brought to the table in the countries where we are in an effort to prevent the spread of disease in their country.

>> Hopefully everybody appreciated it except people in our country.

>> So I want to bring up the importance of genomic data bases in -- especially in surveillance, there's discussion and science magazine at the moment about you say the state of this was

used a lot during the Covid pandemic. cdc set up spheres. There's the European so at some point we've got to have it in one place. It has to be transparent. It has to be sort of no strings attached and I'm not -- cdc absolutely has a role in that. I don't know what the solution is but I just want to raise the importance of that topic ultimately for surveillance.

>> I think it's a huge issue and I think this is one of those things where relatively new field. It's not so new, genomics, but relatively new about using this as a way to detect diseases and I think that there needs to be some basic platform. This is where it all goes. This is the information.

It's interchangeable and until we get there, we're going to have some challenges. It's an enormous issue. Enormous.

>> Thanks so much. Just scratching the surface. We'll have to revisit global health at our subsequent meetings but thank you for taking the time today for this great talk.

>> Thank you.

>> And moving on now to sole duty today to present the data and surveillance and work group report and recommendations.

Julie was unable to be here today so we're counting on you.

I'm sure we won't be disappointed and thanks. You're up.

>> Thank you. Thank you for your attention. I'm excited to present the extensive work of the data and surveillance work group. Over the past two months, with a lot of support from agnes Warner, and others, we've had a chance to present a report. The members have a copy of this and have a chance to review it.

We'll have time for discussion and then we'll have a vote to formally accept hopefully this report as part of our recommendations to the director of the cdc. This work actually builds on prior work of the data and surveillance work group.

Back in November of last year, her first report defined three areas of recommendation that included a minimal data set for core public health, defining that minimal data set, establishing the standards for such data and then ultimately also weighing in on data use agreements. Can I get the next slide, please? Where we are today is we're going to speak a little more on work that's happened since then. Luckily in April of this year, just last month, the new director of the office of public health data, surveillance and technology shared her strategy, public health data strategy. I consider this required reading for anyone who is interested in public health data. It's a tour de force, comprehensive, thoughtful and holds the cdc accountable with specific one-year metrics and two-year metrics. Incredible work. I think it's a great start and what we're talking about today is the work force that will be needed to support this data modernization strategy. The -- one more sentence about this public health data strategy. I think what I learned a lot about is how we can ask an organization at the cdc to be action oriented, aligned with the

moving forward strategy and accountable. That's the new model for all the work at the cdc and I've heard that today in all the presentation so kudos to you guys. Where we're going with the work force strategy is that as we start to evolve the cdc's internal processes and organization and structure, we also need to think about refreshing the people who can lead in the cdc. We have incredible upidemiologstemiologists, data scientists and many others in the cdc but the world is changing very quickly around us and as a result, we'll need to incorporate new skills in data architecture, artificial intelligence and on and on and our hope is in this report, we get to sum up what we need to do. Next slide, please. This will be an evolving strategy.

This is not a one and done. This will require revisiting regularly and what this is, to start us down that road. We focus on three main areas here.

First looking at the work force needs. We need to understand what is missing? What are the gaps? What are the opportunities? What do we have today? Then based on those gaps, what are the trainings we need of people who are there? What are the career ladders? How do we build up the work force in partnership with academia and the private sector? And ultimately, how do we do this?

There are moneys involved. This is not going to be cheap. But we are going to clarify that there are funds out there that can be used for this as well with the final recommendation. Let's go to the next slide. So of the three recommendations that come out today, the three main areas, the first is around creating a landscape assessment of what is going on today with public health data science, what are the capabilities at the state and local levels? What do we have versus what do we need? And then ultimately getting down to the brass tacks by updating the public health informatics competencies. These reviews have been done years ago by phhi --

I'm sorry. phii and the university, U.W. and many others. But I think it's time for a refresh and we as a committee have come back and said that the cdc should help lead that full refresh of the competencies in partnership with these groups and then match those competencies to the gaps we have identified in the public health data strategy so it's not just alone but where -- how do we prioritize what we need? That is the very first step. Part of that will involve the PROOIFRT sector and by the private sector, we're talking about academics, non profits and for profits. One of the laments we hear is we can't keep up with the salaries in the private sector. The good news is, there's been a layoff in the tech sector so maybe we might be able to afford people who are mission driven and want to join the cdc if they understand what they're stepping into and we can tell our story better as we need to. Part of it is also upscaling and training our own staff and identifying as part of that the practices that will help promote equity in the work force as well. Diversity and equity in the work force. It's all connected. Thank you to the work of hew to draw the line in the sand earlier today. It has to be part of how we think about our future as data scientists as well. So in the near term, there are certainly gaps to be filled but in the medium term, we have to think about capacity building and that includes things like technical assistance to the state and locals, training in place programs for core public health, shared work force models where we think beyond the boundaries of the cdc four walls, cooperative

agreements with other hhs and other agencies that also work on things like standards, relative to public health, things like the fire standards, helios, U.S.

cdi, hl7, all which have direct implications for public health.

I was actually going to make it interactive. If I can stop here and ask for questions and discussions on this rather than the whole, what do you think, David?

>> Sure. That would be great.

>> So the landscape assess many, the capacity building, let's start with that first. If there are thoughts or feedback or comments on priority area one around the work -- addressing the work force shortage.

>> We're springing this on people so they may need to think for a moment. There's a time urgency here and so this process updating competencies and the process of working together to put forward these clear descriptions may need to happen in parallel versus in series. Is that the thinking of the group?

>> That's right. The point is this is not something where we're starting at zero. We have many partner public health associations and others who have thought about this a lot.

There's committees on work force at cste and apha and many others and they are willing, ready and able. They also have many published reports which we can draw on so it's not something that we have a blank piece of paper. We have a very good idea of the kinds of things we need and we have the opportunity to start filling it. It's more about being systematic about the priorities.

>> Respectfully when you think about hospitals and the academic institutions, add health plans, when I was the chief medical officer of the health plan, I looked at data every single day for 20 million people and so there's some skills in health plans of data analysis and predictive modelling and -- of diseases and every year we knew what the flu season was going to look like and we also looked at our data and there's a lot of richness of knowledge in that group. You have the experience of being in an integrated system but even the big, big health plans that are integrated do a lot of this work.

>> You're right and what happens is that, for example, during Covid we did run to KIEZer and say what did you know about vaccine efficiency? They had data and abilities in house that they could spin up overnight and we didn't necessarily have all of those in house at the cdc at the same time. To the extent there are lots of pockets out there, the broad areas of non profit, for profit, academic are meant to cover all of the above and some non traditional partners. I think we have a lot of work to do to think about the PROOIFRT sector as a whole in terms of what they have in house, speaking with some of the large pharmacy associations, large -- the top four pharmacies in the country in house they had a lot of abilities around Covid and data science which certainly helped us as a nation but could be better integrated into our own capabilities.

>> As professionals that may have the skills we need to bring in. Yes.

>> thank you.

>> Even on the slide but a little further down, will we talk about that?

>> Two more comments from Josh and then octavio.

>> My question follows up on Karen's. There's a part of the data network that's really core to cdc like reportable diseases and then there are parts that bridge with the private health system and then there are parts that are totally separate which may be waste water surveillance or, you know, the thermometer company that is out there. You know, they completely novel source their data. As you're thinking about this and as you're talking to cdc, how do you think of the public health role in this? Is it -- how much of it is the core public health, you know, what some people call the core public health data systems, how much is it you want people at public health to have the capabilities or are you thinking public health is doing one thing and another group doing another thing? How does the work force relate to the span of different topics?

>> I'm going to phone a friend and ask Dillon to help chime in on this as well. He's thought about this a lot. My personal perspective is that you're absolutely right and we have to be much more ambitious about what we think about when we think about data than we have in the past. Certainly we have to do things internally to cdc and the recommendations mostly focus on what we as an agency can control ourselves in terms of our partnerships with some of the privates but there's a lot of work to be done there that --

stay tuned.

>> I guess partly, should cdc's concept of the work force be broader than the data systems at cdc?

>> Absolutely. Absolutely.

Dillon?

>> The way I like to refer to this is like the information supply chain in that we are kind of aligned in that we want to have data for action, to have some sort of public health impact or outcome so what is the evidence we need to make those decisions to have that impact?

What are the analytics we need to generate that evidence? What is the data we need to actually do that and how do we collect them going forward? If we have robust requirements that are rooted in that information supply chain to get there, then it helps us to understand how to evaluate the novel data sources and whether they're fit for purpose in some capacity but we do need a way to be -- to look at innovative, non, quote, unquote, public health data sets to see if they can actually help us in some capacity. I know that Jenn and I are thinking through how we can potentially put those capacities to test, those different data sources in different capacities.

>> I think also, one success story, one of many that I've seen is across hhs, those partnership around thinking about public health data, the work that poppy is doing with tesca and onc is a good example where this is data from electronic health records in health care but what are the public health relevant data sets we need to collect on a standardized format from every ehr? Those are active conversations happening across hhs where cdc is taking the lead in saying this is what we need and how we're thinking about it and partnering other folks who have access to other data.

Something that's great. I think my point is just given that conception, it has to be really clear in your work force assessment that you're expecting that capability.

>> This is extremely important and the work force is a great factor. One thing I didn't hear which would be a recommendation of time line. The sooner the better but something tangible needs to be done now. So I just wonder what your thoughts are on what the time line should be for this.

>> Thank you. That's underlining all the work. If it's not timely -- I think we'll get to that in the third recommendation as well. I'll move to the second recommendation. Second recommendation looks at the current landscape of training available and what are the training strategies and cross training capabilities. This is not rocket science. We need to know what's out there, make sure it's publicized.

>> We need to move to the next slide.

>> Thank you. Yes. That would be helpful. And hold ourselves accountable as well. What are the kpi's for what training is working? How fast are they moving? Are they actually delivering what we need? There are many great models out there from centers of excellence to training programs that are up and running already that also focus on creating a diverse work force. I think that there's opportunities to think about novel models for public health that are already used in other areas. For example, the nihk and t programs are grant programs that nih gives to train folks at very early stages of their career. Certainly there could be opportunities along the lines with public health work force training. Loan forgiveness programs and other ways to really encourage folks to start a career in public health. I'm not going to say more. I'll leave it open for questions in terms of the training of that work force.

>> Specifically we've been thinking about certificate programs that can be used by the molecular staff at the labs that they can use for their own promotion series but to expand the knowledge and so some discussion around that would be fantastic. We really like that.

>> I'm a big fan of those kinds of career ladders and we know that with the evolution of large language models, the kind of more routine data efforts that a lot of staff have to deal with, surveys and things like that, will be augmented and opportunities to reskill or retrain those folks into this higher level, hopefully better paid jobs.

>> So just one more. It will be really useful to have -- I mean, if you Google certificate programs, there's a million.

Which are the really good, valuable ones? I certainly don't have the capability to assess that. Is there a way we could sort of develop that information?

>> I think that's a great idea.

We'll take that back to staff as well because I'm sure in other areas they figured out, what are the ones that matter and why do people go for them and train and what's the right cost for them and the form MALTs for them, all of the above. We don't have to start from zero. Great idea.

>> It's something in the past that there was a work force training office at cdc who was engaged with that sort of thing.

The extent to which these are people who would end up working at cdc or with the cdc partners that could be a good linkage.

You know, I think one thing we also heard from cdc is not only the different training but also orientation to public health and I did -- I'm confident public health can do this but it is a challenge. You bring in people from a different discipline that haven't been traditionally a part of the public health team to get them oriented to how public health does things which is a little different than the novel kind of thing that you get in a course. But I think cdc can could that. Yeah. It can do that. Push PUSHL

>> I'll move to the third recommendation. Next slide, please. How can we do all of this? I think we need the clear, explicit, clarification from the cdc that existing epidemiology and laboratory capacity, oelc and public future funds can be used for the gap assess entsassessments, leadership roles, data modernization lead in a given state and support the collaborations beyond academia and industry to do this kind of work training in no time.

Those funds exist today. The opportunity exists today. The need exists today and I think that just has to be clear and we need to say that. I think there's still confusion on how those funds can be used. Any comments on priority area three?

>> I was curious, my understanding is that the elc, only -- there's not only the jurisdictions receive the elc funding so can you talk about the work on that front in terms of additional resources perhaps that might be available?

>> We'll triple confirm but my understanding is that every jurisdiction at least gets the base elc. There's also a sub component called els enhanced. I don't know if that is distributed across all jurisdictions or not but the base elc, which this would come in the rubric of, is something that all jurisdictions receive.

>> Thank you. We make a good team.

>> I just wanted to say that there's a number of different grant programs that are supporting some infrastructure dataed on -- data modernization, the elc or even some of the more specific std, I think there's opportunity here to coordinate across the various grant mechanisms to support such a -- this type of work force that is not -- because we're very siloed, I think, in some grant mechanisms so for state and locals, it would be a great opportunity to build that kind of capacity across multiple mechanisms.

>> At least from my perspective, this seems like an obvious recommendation. On the other hand, you may wish to speak to this but my understanding is in the working group, members of the working group who live closer to the front lines, there was considerable confusion at the level of the folks who were right in the grass and the leaders to the extent of which the funding streams could be used for modernization staff and there was some urgency, if you will, in trying to clarify this.

>> I would also welcome any of the other work group members who were on esw to highlight this.

We have a few minutes. I hope we were non controversial. With that I would like to see other time back after a vote. At this point we would like to take a formal vote on the recommendations as promulgated with some feedback that we will incorporate at the working level opposed to in the formal document. Could I get a --

someone who will say they will vote for this?

>> I will.

>> So moved.

>> Second.

>> Second.

>> All those in favor, please say aye.

>> aye.

>> Any nays? Any abstentions?

Thank you.

>> OK. Congratulations to the working group for that great report and thank you, acd members, for translating those into actual recommend ages from the acd that will not go to cdc and hss. We know from the folks on cdc that they've been working for this and we look forward at the next meeting to hear an update how the recommendations have been viewed and implemented and you're right. We are a little ahead of time. And so what I would like to do is to go ahead and take our 20 minute break now and reconvene a couple of minutes after the top of the hour. Maybe get out a couple of minutes early. Thank you.

>> Let's begin to take our seats, please. So welcome back.

We wanted to do one thing before we get to the next agenda item.

And it's to make a special acknowledgement. One of the realities of being on an advisory committee and the way it's structured is that people rotate on and rotate off. We're not permanent members. And believe it or not, that's already starting with this committee. And so this is crystal's last meeting and we're going to be rotating off.

Crystal, let me start by thanking you so much for your service. You've been instrumental in reconstituting and revitalizing this community and I appreciate your participation in the work group and just the energy you bring to the meetings.

>> I just really want to echo David's thanks. cdc, we're so excited to reconstitute the acd with all the new members on T.

It's been amazing and to having your input on things like data, all of the feedback that we've received from you is really, really helpful and we hope you still will provide guidance.

Thank you.

>> thank you so much. It is really an honor to serve on the committee to be able to provide I be put. I think the work that acd does is important and it's been great to know some of the leaders and fellow acd members as well. I'm going to have to duck out of the meeting a few minutes early so just apologize in advance but thank you very much.

>> We had a conference about appropriate time to leave here given when your flight is and I suggest she leave a little early. That's my doing. For the last sum on our agenda, a very important one and we would like to turn this over to the laboratory working group and Jill and Josh to present a report to you and some recommend ages -- recommendations for a vote

>> Thank you very much, David.

I'm going to do most of the talking and Josh is going to jump in frequently, please.

>> I thought you will say I'll do the associated dance moves.

>> You could. OK. So could we have the next slide, please? So the terms of reference that we're addressing, we have been addressing for the last few months is the terms of reference one that we were asked to look at at the beginning of the acd.

It pertains to something that happens in all large reference labs in that sometimes you receive a sample that is -- it's been longer in transit, has a volume that only gives you enough to do it once rather than twice, it may be above temperature. So you have to make a decision as a laboratory director, should I test this in a way that gives results that are accurate and reliable and can be used by a physician? Or should I reflect it? It's a very tough position to be in. So cdc has, in the past, been in the situation of receiving the samples because they are the premier reference laboratory in the country so the cdc is the lab of last resort when you can't find anywhere else to assess something. They come to cdc. cdc is also clear laboratory and therefore, has to act under clear standards. And so is there a way that cdc can accept the samples and test them, still meeting clear requirements? So before I go on, I want to say what clear is and what cms is because the terms are often used interchangeably.

And it can be confusing. So cms we know, all of you know, is the centers for Medicare and Medicaid services and cms oversees all of laboratories doing testing on specimens from humans. That excludes research but all diagnostic testing. The regulatory vehicle that cms uses is called clear which is the clear laboratory improvements amendments of -- it began in 1998. There have been many amendments since then and essentially the role of cms using clear is to ensure accurate, reliable and timely patient test results and to do this, there are a is hes -- set of standards that all clear laboratories must, must meet. So I just want to set up what the definitions are. Next slide, please. Next slide, please.

Thank you. So what have we done?

We met -- have met twice, on April 4 we met with cdc staff and then I want to at this point thank the cdc staff, especially Wendy who have been terrific in helping us address this situation. They've been very forthcoming and they gave us examples of specimen scenarios with cdc didn't test samples that didn't meet their acceptance criteria. They were outside the usual parameters. We met again just -- just the lab group met on April 11 to discuss the report we should put together and we have since then written a report that provides one recommendation and several processes that cdc should adhere to. Josh wants to --

>> Yes. Just to say I think the question for the laboratory work group was cdc gets these samples, is regulated, there is this desire to be able to make good decisions about the samples, how do the pieces come together? What is the right way for the lab to do both meet the public health objective and the regulatory objectives basically.

So just sort of putting a point on the question as we get to --

well, so what should cdc do?

>> Yes. Terrific.

>> Actually just for the group, for those of us not laboratory scientists, can you give a couple of examples? When I heard the examples, otherwise I thought it was like a degree off. NITH I didn't get it.

>> Child taking a csf sample. Or ups had a failure in the sample ended up that ended up in hot state, Louisiana for two days and so when it came, it was thawed. csf is a good one because -- well, I'll get to that in a minute. It's hard to get enough to validate.

>> I'll just jump in and say, what I appreciate -- you know, maybe because I'm not from the lab world, I can kind of explain, you know, the concept that was very helpful to me is that each test has a validation that explains the parameters and that can be a narrow validation or a wide validation.

>> You're jumping ahead.

>> I know but as an example, we have great meetings, by the way.

I'm just saying. But -- so say there's a narrow validation for a particular test and it's good for blood and urine. But the sample comes in for csf can has happened at cdc is one of the cases presented to us. The validation is not for csf. So, you know, on the other hand you're worried about meningitis.

What does the agency do in that moment but also how do you prevent the moment from happening? So you're in that situation.

>> We do have good meetings, don't we? We educated you on lab stuff really well. So next slide, please. So the unanimous conclusion was that the cdc should offer this laboratory testing for unknown, rare, important or difficult to diagnose agents, even under the less than ideal circumstances and it's important to -- when I said earlier today that public health labs would always exist, this is one of the reasons because public health labs, including cdc, test specimens of public health significance, including what could be emerging pathogens so it's an incredibly important role. It's an important role for the population but it's also important role for the individual who has the disease that the physician is worried about. So it's an incredibly critical role that has to be supported. I wanted to talk a little bit about what a validation is. Josh brought up that term. It's essentially testing your protocol. My protocol is to do a pcr with these primers, these probes and the temperature has to be between 20 degrees and 22 degrees. So test it broader.

Test it between 18 and 24 to give you some flexibility in what you can accept. And if the result is still valid, then you have the data to say, OK. Within those extended parameters PSHGS I'm OK to test the sample and trust the result. Good?

>> Right. So yeah. Exactly.

Thank you. Well done, Jill.

>> thank you. OK. So we also think -- can I have the next slide, please? That it is possible to do this and on our lab work, we have some members who represent very big commercial labs and medical reference labs as well as public health labs and the processes that we're going to describe are what they used in their labs.

OK. We think that it may well involve some changes in process at cdc and potentially some policy discussions with the cms.

Next slide, please. So we already talked about this a little bit. The idea is to do a broader validation than you would normally do for a perfect specimen and to test beyond --

test the validity of the test beyond the ideal state so different volumes, slightly he can up and downed temperature range, longer times in transit, different specimen matrix, things like that and also the collection device so that you are assessing data in a broader scope and really, really document this validation very well. The step after doing the validation is that that data goes to the clia laboratory director along with the context of the specimen to say the specimen comes from a child in the icu with these symptoms and the -- given the data that cdc has now developed, the laboratory director has the data to support to say, yes, I can believe this test will give an accurate result under these conditions. And that gives him, based on their own experience and in the power of the data, he can accept the specimen. Yes, Josh?

>> Yes. So I think the idea is you have a broad data validation that you can reasonably do but also a standard protocol so this -- the ideal, the expected sample. We're going to validate it from 18 to 24 degrees but are expected in the regular protocol to be 20 to 22. Comes in 20 to 22, everybody did it. Comes in at 23, it goes to the lab director, you know, to make sure that they're comfortable with it. It comes in at 24.1, then that is a decision for the lab director based on what they really understand about the validation. The validation is giving -- basically the decision about whether the validation means the benefits of the test outweigh the risks and the wider the validation, the easier it is for the laboratory director to make that decision. What we heard in the discussion, in their mind, and we're talking to laboratory directors at major centers and they do this. In their mind it's not going outside the validation if a lab director is looking at a broad validation and making reasonable imprints about what should be OK. That is a highly technical decision and sometimes they'll say no and sometimes they'll say yes. And it helps to have that broad validation. If you have only validated 20 to 22 and it comes in at 24.is, you're way off. It's very off. If you know everything you tested is great up to 24, and 24 is reasonable to infer that it's OK, this is how I understood it.

>> You're good.

>> And so --

>> We'll give you a white coat.

>> The idea here is that there's a zone where it flies right through and there's a different zone where it should be up to the clia certified lab director to make the decision. That's not how it happens. It is a description of how we think it should happen at cdc but also a description of how it does happen at labs around the country. That was kind of the key. To align this with best practices allowed around the country where it is, you know, in this kind of mindset, that's the idea and part of the issue, I think, is the -- maybe some of the validations could have been

broader in the first place. Then you want to have a clear protocol for how exceptional samples get referred to the lab director and then reviewed and documented if decisions are made one way or the other. You can get the best minds to talk over particular questions that might come up but ultimately it should be the lab director's determination. We could pause on this. This is probably the heart of the matter a little bit.

>> So this is very helpful so presumably the 24.1 scenario, were the laboratory director to decide to proceed, there would need to be some con textural result?

>> That's coming. Yes.

>> Next slide, please. So there may be situations where it can't be tested at cdc. But it's important for cdc to know the test menus of the big reference labs around the country and they may have done a validation that says this is OK so it can be referred. The negative about that is that it takes time. You have to ship it somewhere else unless you can -- unless you know the sample is coming in and can work this out beforehand but it is possible to refer and that happens all the time. That's why samples come to cdc because the lab that -- say the state lab it comes to can't test it. OK. Now, this is where the question comes in. If a sample can't be -- no.

Next slide. There needs to be a disclaimer of sorts on the report for the physician. It's explanatory to say this is the result we have. We believe the result is accurate but you need to understand that it had an extended transit time or something like that.

>> Just to be clear, that's not just for the 24 TOIN -- 24.1 scenario. It may be the 23 scenario. Anything that's not necessarily part of the usual standard, it may be like, look.

This is out of the most usual range. It depends on the particular test. But it may be appropriate to put a note on based on the circumstances.

That's why it goes to the lab director even if it's within the overall validation but not what was expected or recommended to the ordering clinician. Yeah.

>> You may get to this.

Apologies. But you talked about the lab director being able to look at the specimen, giving a validation study they've done and how close they are falls from that. Is the lab director allowed any discretion looking at the circumstances of the specimen itself?

>> Right.

>> Is this a one time thing and there's no way you could get it again?

>> There's a benefit/risk determination.

>> Not just validation.

>> The content. If you can get another one with no problem, then that's the right thing to do. Exactly.

>> Sort of connected to what was done on the prior slide. Can the lab director say, you know, our validation study, we expanded it to go to 24. Yet now I have a sample that's coming in with a temperature control of 24.5. We don't have the time to redo validation study but lo and behold, I looked at the S.O.P.

of a validation study from another laboratory and they used substantially the same method as we do except that their validation was done from 18 to 26 and therefore, I believe we're in good stead because our methods are substantially similar. Theirs just cast a wider net. Is that sort of move a lab director could use?

>> So can I answer that as a lab director?

>> Go ahead, please.

>> It depends on the lab director. From my perspective and the risk of the institution, as a public health lab, being a lab of last resort, my bias for a pressure specimen is to test it if I have enough context in the data I know. I would take into account it's a dna virus, genetic material is likely to be stable. rna virus I might think differently about. It's really the experience of the lab director and his or her knowledge as well as the context.

>> I would answer slightly differently which is I think if you go to the side where it says if another lab has a validation, you can get it to the other lab, that's a viable thing to do.

>> Except it takes more time.

>> Yeah. That's a factor. So you wouldn't just say, well, someone else did it so we're going to do it if you had the time. If you didn't have the time, that would be a different kind of thing and I think it's partly, you know, that's where it comes a very difficult question.

>> Are you capturing the learnings from all the lab directors so we can update clia or do the validation studies later?

>> That's one of the recommendations coming, yes.

>> Can I ask a quick, ignorant question? Can one clinical lab director consult with a peer?

>> Yeah. Absolutely. You do it all the time.

>> I was assuming but didn't want to assume.

>> So this really relates to a question that just came up. Labs have to do continual quality improvement. You have to keep pushing your protocol to make sure it's accurate to make sure that you use the optimal sample and you do that quality improvement based on the data that's coming in so cdc can look at the samples that have come in in a sub opt natural way. Are you

getting samples from one particular laboratory that are always less volume than you want? So you need to work with that laboratory and say, hey, we need more. Or they're using a carrier that's not dependable and doesn't get you time. And also -- so I work with the submitter but also see if you can extend your validation broader and still get accurate results so that's something that has to be done all the time. And that clinical labs do all the time. Now, this is -- next slide, please. This is something that we suggest, having one clinical lab director is a risky situation for multiple reasons.

We really think that cdc should invest in multiple clinically qualified, clear qualified laboratory directors and have them above the various clinical units so that their knowledge is really deep in that area. You know, virology, whatever. That puts you in a much, much risky situation and I think that's the important thing for cdc to consider.

>> Our sense is that cdc may be making decisions now, one person for the whole agency. All the labs. And by necessity as opposed to having it by people who are experts in that particular area which may make them naturally much more conservative.

>> Yes. Next slide, please. So this may require some discussion with cms. And we think it's important that cdc needs to reach out to cms leadership, talk about their plan and gain the understanding that this is an appropriate and accurate way to go forward given the public health importance of doing this sort of testing. They should involve hhs if necessary and this is a subject that is dear to the heart of the association of public health labs and it may be value to -- valuable to include them in discussion. But that it is important to get this right because of the public health and individual importance of the testing. This is not something that cdc should not be able to do under appropriate regulation.

>> I would just say that maybe I'm inferring a little but I think there's a little bit of question at cdc whether this approach, which as we said, the standard of practice in major labs, is something that, you know, current cms oversight would welcome or not. And so this is where I have a little bit more experience than all the technical issues. I think it's a very fair discussion with the leadership at cms to explain the public health goals to reach for and to make sure there's clarity on some issues that could go down with the inspection so you don't get an inspector who is confused about the approach cdc is taking when it's been clearly worked out under clia with the senior leadership

>> And well documented.

>> Can I ask just a followup question there? I'm assuming because this is the practice in larger commercial laboratories, it is the working group's understanding that this proposed approach could accord with the clia regulations as they are currently written.

>> That's right.

>> But your point is that for extreme clarity as well as potential other opportunities, cdc ought to initiate a high level discussion with cms.

>> cdc is an unusual lab in some respects so I think just because of the nature of the samples and other things that come in. We think that it is clearly within clia to provide the kind of approach that labs do it now and that there should be -- it should just be clear, though, because we picked up that there's a little bit of lack of total competence that every inspector would understand but it takes two to tango here. I think that's the key approach.

It's not just about cms. It's about cdc developing an approach affirmatively how it will do this to the extent possible with multiple lab directors, explaining the approach to broad validation. You know, there's a lot for cdc here, too. As cdc is changing its approach to this question, it's a good time to hook up with cms so downstream you don't have a problem.

>> At the risk of being repetitive, please forgive me but just to confirm it is the working group's understanding, belief and explanation that this proposal can move forward with the broader discretion to the lab directors and in parallel, a discussion with cms can happen rather than cms having to precede the broader discretion to lab directors. What's the order of operation there?

>> I think the first thing is develop the plan. And have a protocol. Excuse me. You talk for a minute.

>> I was going to say the same thing. I'm like the dummy. But having an approach that cdc is going to take, that cdc feels comfortable with for the labs, this is the approach it's going to take, if there's going to be consultation when there's --

under certain circumstances and the consultation isn't just something outside the validation. It's something outside the usual. Broad validation as possible, give an explanation to the usual, something comes in that's unusual, you have a protocol for it and part of that assessment is whether it's consistent with the validation and bringing that plan to cms as you're beginning to move it forward.

>> So with cps and clia, it's important to have layers of verification of accuracy so you design a protocol. You document like hell and then the second step is the clia lab director and then is there another lab to be able to test it? And then have a considered the context of the specimen? So it's not just having -- you don't just need one thing. You need multiple layers of assurance and that says to cms, I'm taking this seriously. I really need to test this specimen or I just can't.

>> I feel you probably know the answer to this question. It's my understanding, and it may vary state to state so I might be wrong but it's my understanding that a clia lab director is limited to how many labs they're allowed to be director of and that if the cdc has one director, then it must be they have a regulatory paper that it must be a VERT FIEed lab. So they have to separate their labs as a clia lab and then from that point onward having to have --

and now you're allowed to direct more than one but I don't think you're allowed to direct half a dozen or --

>> I thought it was like four or five that you can direct.

>> I seem to remember the number four. We went through this when we set up the Covid labs. But the other thing I seem to remember is the resource issue is the qualifications, the training and qualifications that are required by cms and so I think that's another thing that cdc would have to look at.

There's a pragmatic issue. The last thing I want to say, if indeed this recommendation, which I support, by the way, were adopted, that it would need to be clear that it's OK to have somebody directing more than one lab because you do have a problem if somebody leaves, then you have no -- you know, you need to have people.

>> If I could jump in, I don't think we contemplated that someone would direct more than one lab.

The reason to have multiple labs would be to have multiple lab directors.

>> When the lab director leaves, while you're looking for the next one, someone may have to have more than one.

>> Correct. This relates to one of the recommendations of the work group, that the committee adopted before which is a lot to do with work force and strengthening the number of highly qualified lab directors at cdc.

>> It would.

[Inaudible]

>> so do you want to go through the official language of proposing a --

>> Sure. Any other questions?

First? I guess we're looking for a motion to see whether our recommendations would be adopted. David, turn to you.

>> I would go with the motion to take your proposed action steps from working group and have them be recommendations to the cdc.

>> Very well, David.

>> So moved.

>> All those in favor?

>> aye.

>> All those opposed? Hearing none --

>> Abstentions?

>> Any abstentions?

Congratulations. Thank you very much for that excellent piece of work. And the report is adopted.

Recommendations are adopted and the other recommendations from today will head up to hhs. And we are now at the end of our meeting. I'm going to be relatively brief but not so brief as to not thank first off, all the acd members for your participation today. And even more importantly, all of the cdc folks, presenters, incredible support staff that we have in this committee to make these things happen. Our dfo, cdc leadership, it's fun for all of us on the acd committee to have this partnership with cdc and we made great progress today collectively. In hearing from a number of the different parts of the cdc so thanks, henry and all of the cdc presenters on health equity and global health programs and overall agency direction, readiness and response. And thanks to the work groups. My goodness. You know, it's great for us being on the committee to be able to be here but let's not forget that our work groups have lots of folks on them that are not part of the acd, who are volunteering their time to be part of the work groups in a fairly thankless way.

>> To emphasize the lab work group has been tremendous.

>> Yeah. Yeah. And not alone but --

>> Tremendous.

>> Yeah. So thanks to all of those work group members as well. I'm going to turn this over to Deb for final words but once again, just want to also express my personal appreciation for the opportunity to be part of this wonderful process.

>> I want to echo David's thanks and particularly to team members at cdc. You know, many of our staff here have advanced degrees and are staffing the committees and providing a lot of expert of the work group, dfo's and I know that as dfo of this committee, I've been so expressed with all the work you as members do. When I'm sitting in the audience, I wasn't as aware of all the work that happens on a regular basis by these work groups so greatly appreciate that and for those of you that made the trip out here and certainly for Rhonda, thanks for hanging with us this whole time but your expertise in pushing us is always greatly appreciated. Do feel free to give your comments to me or David. He and I are always looking at how to change up the meetings a little bit. We had our senior leaders at the table with us. We look forward to engaging them even more.

Hopefully the conversation at the dinner last night was helpful so there's just other things we can do to make these more interactive, both useful for you as well as for us. I do know that at our next meeting, we'll have some of our cdc experts come back to present progress on the recommendations because I do want you to know we take your guidance really thoughtfully and want to implement what we can so we'll give a progress update on that and lastly, a huge, huge thanks to David who is always available when I have questions or concerns and always has

great ideas and again, his ability to be on every work group and always available is -- just his guidance and expertise is greatly appreciated so thank you all and I hope you have a safe flight back.

>> We're adjourned.