>> Laboratory facility within this branch that it will be available to support clea testing during any public health response. That did not exist before Covid. We have also building within this branch hopefully over time as Vicki alluded to, a more standardized process across the agency for new test development as well as for test deployment from CDC out to the public health laboratories or clinical laboratories as necessary. So again, standardizing the way we think about laboratory preparedness in response from the CDC so we're less reliant on just individual subject matter, expert laboratories to handle all response functions.

The other thing I'll do quickly is talk about a couple of initiatives that we have taken over the summer and in this fall that hopefully recognize many of the comments and recommendations that came from your laboratory work group.

This is a request for information that was out to the public during October, specifically asking for the private sector to tell us how they could better support surge laboratory testing during public health responses. Now, we were able to surge obviously to the private sector during Covid and also during mpox but both of those transitions from public sector, public health laboratories to private sector clinical laboratories was ad hoc to be absolutely frank and we didn't have a well honed system here, process here at CDC to help manage that transition so we are asking the private sector to help us understand what they would need theoretically if we could identify the resources, how we could contract with them in advance so that that transition from public health laboratory testing to private sector clinical laboratory testing during public health emergencies could be much more -- executed more quickly and more smoothly.

We did receive nine responses, eight commercial laboratories as well as one large government contractor, a lot of great information we're now processing. Next slide, please. OK. Somehow we got ahead a slide or we missed a slide.

OK. So thank you. This is the second rfi that we now have on the street. The first one was about surge testing. The second rfi is about test production and test modification so we need help, clearly, from the private sector to be able to very quickly and with high quality develop new tests, especially if we are encountering outbreaks of disease that we are unfamiliar with or that for which we do not have a readily available test.

Historically as you know, we've relied on the sme lab to be responsible entirely for that test production. We want to diversify that capability and be able to engage appropriately with the private sector for help in doing new test production but also perhaps even more importantly is test modification and we needed to do this during the mpox outbreak where we needed to rely on commercial laboratories to take an existing CDC test that was a relatively simple test but not

used in a high commercial is hessing and modify that test and get that test modification approved and authorized by fda before we could take advantage of the high through-put testing in the commercial laboratories.

That took time and five commercial laboratories offered to do that for me and we don't want to count on that in the future and we also don't want to have to spend the time during an emergency to do that kind of work. So this rfi is asking the private sector to tell us how they could help us prepare better our existing test for high through-put settings as well as to develop new tests when they're absolutely needed.

We've awarded a contract to Griffin scientific and this is at a more high level but it was something that not only the laboratory work group called for but also many publications by outside experts have made clear over the last especially six to nine months and that is can someone please, in the government, define this national laboratory response system and how it works and what are the roles and responsibilities of all the various players in this complex system that spans hospitals and special laboratories and physician office labs and urgent care centers and nursing homes and public health labs of various capacities and sizes and how do they all work together and what does it look like? Can we articulate that in writing in a way that helps everyone understand their roles in advance of an emergency rather than we figure it out on the fly and so we are going to work really hard over the next 12 months to do exactly that and obviously we will reach out for considerable support from many of you as we develop this report and hopefully be able to publish it within the next year.

And then last slide, please, just a summary of what we're hoping that this new center will be able to do. Cross cutting laboratory operation and systems support for all of CDC's infectious disease laboratories including the standard I'dation of test development and deployment as well as support for laboratory animal studies.

This is the place responsible for engaging not only CDC but all of our federal partners in this laboratory and diagnostic space. So whether it's fda or cms or barta or aphl or acla or all of the organizations that are so deeply invested in this field, this center will be principally responsible for engaging and ensuring we understand their concerns and their capacities and they understand what we're trying to do.

So with that, I'll stop.

But again, I want to express my thanks, especially to Josh and Jill and the laboratory work group for the work they did in helping us shape many, if not most of the ideas we're trying to implement with this center.

>> Great. Thank you very much.

You've been busy. Floor is open.

>> thank you for your work. I am really excited by this work group and the fact that the word "response" is right there in your title. That's such a clear message to everyone. You spoke at the end about some partnerships across cms and CDC and others. I was wondering how that is shaping up, very specific until -- specifically in regards to the new data office and then the cfa with Dillon, center for forecasting and outbreak. That's also response. What other partnerships or what are you thinking about in those two spaces?

>> you're asking -- I want to make sure I understand your question. The question is specifically about the internal partnerships between this center and their office? Absolutely we recognize how important their roles are in preparedness and response and I would say that the relationship between this brand new center and Jen laden's office is much more mature than it is with cfa. The reason I say that is because we've been working in my old division, the divisional laboratory services with the office and the dmi program for years now. In fact, our electronic test order and result reporting work, the laboratory data exchange strategy has been central to much of the work of the division of laboratory systems for years and as a result, we've been actively engaged with her office and her staff throughout and so I think the relationship is quite strong.

cfa is still getting itself stood up and we've had lots of meetings with their leadership. They know who we are, we know who they are.

I'm not sure that I would say the relationship -- I did say that the relationship is not asthma tour because we're not doing active work with them in the same way that we're actively working with the dmi organization.

>> Thanks, Josh.

>> Thanks. I want to start by just appreciating all the work that has happened at CDC and also just the incredible operation the work group had with the people at CDC talking about these jobs very candidly and it's just really great to see this moving forward and I completely accept that it is everything you've talked about, so much in line with how the work group which really brought a lot of different views together really helps so it's good to hear the presentation.

I had a couple of quick questions just following up on maybe some of the minor points in the report. One of them, as we look back on that Covid test was that the emergency response structure didn't have all of the labs that were part of making that test kind of under it. I wonder whether you think that is -- you know, whether you've gotten to kind of the design of the incident command that that challenge could be resolved. It could be any test, not necessarily those kinds but the incident command could look over not just the core labs but also the other particular labs so there's like a coherent management in the crisis and then my second question is that one of the other recommendations was to consolidate labs at the division level or to the grants level and just what -- you have plenty of chains that you're managing right here but how you think about that recommendation now.

>> Yes. So I'll start with the second question and then turn it back. Before I do that, I want to echo what has been pointed out and like Josh was pointed out. We did enjoy working with the laboratory work group.

It was a great exchange of wonderful ideas and we really value all the input that you gave.

We are working towards consolidating laboratories at the branch level. I can't give you an overview of how that is to all of the different centers today but I know that is actively being pursued and I know actually Deb lowry is making sure that moing forward.

We are working towards the branch level.

>> Thank you for your question about future responses and sort of centralization of laboratory activities. This is from my point of view, my perspective. I think, you know, we need to stand up the center. We need the center to be recognized as adding true value to CDC and the overall public health system and I trust that once we do that that the community and the culture within CDC, especially that thinks about how we organize ourselves during public health responses will recognize that this center should be, you know, at the forefront of laboratory operations and thinking for every response. And that the center will have some sort of -- you know, in my vision is that the center would be -- have a permanent seat, if you will, within our graduated response structure such that every response that looks like it could be of any significant size or shape would have to include the leadership that comes out of the center for laboratory systems and response and that it would be incumbent on the responsibility of this new center to ensure exactly what you said which is that we are not -- that we're taking an agency systems approach to laboratory response and we're not putting all of our eggs in the basket of an individual subject matter expert laboratory but that we're immediately bringing that expertise into an organization that has, you know, a lot of expertise in general around test development, test distribution, you know, test laboratory data exchange and so -- but I think it will take some time for the center to establish that reputation and be given that responsibility.

>> But I appreciate just a super quick followup. I totally appreciate that and in a way, that question really isn't as much addressed to you because you're doing the work you need to do as it is more generally to the CDC that, you know, you can have a great center and a lot of expertise but in the moment it's really important that somebody is empowered over all the different labs so you don't have a situation where the labs are pointing a finger at each other and things can happen in the gaps between the labs in an emergency. However that is done.

>> Yeah. Thank, Josh. There's a comment at the end. Julie Daniel and then last by Doug.

>> Thank you so much for your presentation. I just -- first I want to just commend you for the work, first the laboratory work group and also you all for the work that's been done. It was so clear that you took the recommendations to heart in our responding to them really thoughtfully and carefully. I was really impressed with it.

I am impressed, too, that it's not glamorous, shiny objects that you're addressing but really looking at the fundamentals of the work that need to be done so thank you for doing that. It's necessary and so valuable. I have a question that builds on Josh's a little bit in terms of the -- how much power and authority that you have. I'm also wondering about the resources. Do you feel that you have the adequate resources to stand up the center in a way that is most impactful? I think part of it is that I see you're doing things in a systematic, slow way. Is that because of you wanting to be careful or is it a matter of lack of resources?

That's a question for you all.

The last thing I'll say is just I think building on your comment, I can see a place for us, the initiative working closely with you all as they move forward. I think when we look at the future tor, I think there's an incredible need for a collaborative effort across the different offices and I think nears great opportunity as it relates to data exchange. Thank you so much.

>> I think what I would say is I'm really proud of the agency for moving forward with creating a brand new center in a challenging fiscal environment.

And unlike the center for forecasting analysis, there is no Congressional mandate, much less Congressional line item that specifically said this center must be created and here is x millions of dollars a year to sustain the center. And so from that perspective, I would argue that it was -- it took a lot of leadership for the agency to declare publicly that we would create a new center which doesn't happen very often as far as I know at CDC and frank many, there's never been a laboratory specific center in the agency's history to do that without the assurances of a Congressional line item. So -- but with that said, you know, I think there's a fiscal reality here and --

which I will appreciate that we have no choice but to stand up the center in a deliberate, admittedly gradual fashion to take existing resources that the agency is willing to redirect to help stand up the center and that it is incumbent upon those of us response I will for the center to, you know, help demonstrate its value and help build its reputation both internally and externally and over time, we trust that the resources will come and will increase.

And I think that goes, you know, back to the earlier question about it's responsibilities and, you know, those responsibilities will evolve over time as well, right?

And I think initially, you know, right now there's only, I think, three employees in the center and we're trying -- we're actively recruiting as fast as we can but we won't be able to hire hundreds of people into the center. We don't have those resources today. But I don't think that that's necessary for this in the short time for the center to succeed and I think that we can, over time, build the center and its reputation of internally and externally and I think the elevation of our relationship with the broad clinical laboratory community is going to be really important and will really give us -- could result in a lot of support outside CDC for this center and I think that will also, if we're successful, you know, help the center grow and as the center grows and its

reputation improves both internally and externally, I trust its responsibilities in future responses will also grow.

>> Thanks. Last fairly quick question.

>> Thank you. I, too, want to thank you for that insightful presentation and just wanted to make this comment and then ask a quick question. One of the things we struggled with in this country whenever there's disease outbreaks, pandemics, is realizing an equitable response and I wanted to build off the question by asking, how have you all been engaged with the OT of health equity to ensure that we can realize an equitable response in the future? Thank you.

>> Yeah. So absolutely great question. I will acknowledge that I've had this job for about a week and I will tell you that I personally, in this job, have not yet engaged the office of health equity. I will tell you that on the org chart, among the first ten positions in the center that I currently have funding to fill is a senior health equity coordinator and so it is absolutely central function as far as I'm concerned for the center to have health equity square and front and center for the work that we do.

And I hope that's an adequate response and I hope that in the future I'll be able to demonstrate more work in that area.

>> Thanks very much. I'm sorry.

octavio.

>> Thanks, David. What a great presentation. Thank you, Victoria. Thinking about future responses, I was just asking the talk from the layman's perspective thinking about the status of the data exchange with all the clinical laboratories so I really appreciate that slide showing the public private laboratory eco and many how complex it is. Thinking about that and how the new approach and center, could you tell us where we are currently from your perspective about OPer ability with all the departments and what time frame to improve that ability for data exchange which I think is critical for the next phg when it does arrive, unfortunately.

>> OK. And I can't just defer that question to Jen layden. I think, look. We have made tremendous strides during the --

we made tremendous strides during the pandemic in what we call elr or electronic laboratory reporting. There was very little laboratory reporting of public health data prior to the pandemic. During the pandemic, you know, for the most part, the overwhelming majority of laboratory test results were reported electronically to jurisdictions and then from jurisdictions into CDC as well as the federal government.

And that was a huge leap forward, if you will, for laboratory reporting. I know you're asking a much broader question about inner OPerability which is -- yeah. I think we'll be working on well past the end of my career. Where I think we're headed next and what we're working actively on is not only one way of reporting from the laboratories that are performing the tests

to the public health department and on to CDC but is a more fluid two-way electronic reporting system such that both test results -- not only test results but test orders are transmitted electronically from one facility to another and those results are transmitted electronically back especially when the orders and results cross the sort of public health care boundary.

We have a lot of work to do there, but we're making a lot of progress. On the laboratory front, you know, what we are envisioning and again, Jen layden's organization is responsible for this and leading this but we are supporting it because of the piece of data modernization is the concept much using intermediaries, specific intermediaries, the hphl and the report stream that the CDC intermediary that will allow any entity, any laboratory that is performing public health tests to send their test results into those intermediaries through it and those intermediaries will standardize the data and the elements associated with that data and automatically distribute those results to any and all entities whether it's jurisdictions, the federal government or CDC that need that data instantly. And also be -- those intermediaries will also enable the deidentification of that data, right? So that only jurisdictions receive the identified data, the government and the CDC would receive the deidentified data. That process has historically been very complicated and time consuming and really slowed down our response but we do envision, if we can persuade the broad laboratory system community to engage and use this intermediary concept that we will significantly improve the --

what we're calling the laboratory data exchange system that will not only benefit us significantly during public health responses but also just improve health care in the interoperability between public health labs and laboratories and the health care system. It's going to take a long time. It's going to take a lot of work and a lot of resources but I do think we have a good strategy there.

>> Thank you. I appreciate that elegant answer. It's an elegant vision.

>> It's gratifying to see all this response from you. Thank you very much and we are running short on time so Rhonda, a quick question?

>> Not a question.

>> Rhonda, now you went on mute again.

>> That's because I sound better on mute. No. I was saying, no questions. Actually just a warm appreciation for the presentation you just provided.

You anticipated our questions, showed us your progress to date which is pretty significant.

Love the new work structure and just your responsiveness to the input from our committee and from stake holders. Job well done and congratulations in your new role.

>> Thanks for that commented, Rhonda. Last comment to you, Deb.

>> Thanks, Rhonda, that was feedback that came from all of you that our work groups, we appreciate the recommendations that are generated by you all so we want to make sure that CDC today in particular for each of the sessions we're able to talk about the progress made. I really want to thank Jill and Josh for all their work with the lab work group. Certainly ren and Vicki and then can't go without thinking Jim who was really -- had a vision for a lot of this. I did want to be clear.

For funding we have zero dollars for this, additional dollars, and when Shari presents the Covid recisions, we had some plus ups for one time funds that we were able to do for some of these activities. That's gone away. And so we are doing what we can within existing or decreasing resources. I want to be very clear on that. There's a lot we would like to do but are unable to do because of restraints.

I'm really proud of this group and all the lab scientists. Change is not easy and I can tell you I participated in 19 listening sessions with lab scientists, lab administrators across the agency around a lot of these recommendations and the structure. We certainly, my vision was division level but you have to bring people along.

You can't force things on people and so branch was the way to go for now and even that has caused, you know, a lot of angst and con sternation and lots of phone calls so for us it's moving things in the right direction and the constraints we have and we have an S.O.P. for response now and we're looking at how we do responses overall with graduated levels. I think we're in a much better place in part thanks to the lab group and the group of scientists and leaders at CDC so thank you all.

>> And thanks very much for coming this morning and presenting. You see there's a lot of interest here and it's really gratifying to seeing the progress and we look forward to continuing to work with you. And the laboratory working group is not quite done because there's still two elements that they're -- in terms of reference that need to be presented and voted upon. We're running a little late. Josh and Jill, you're on.

>> Thank you and I will talk quickly. Next slide, please. And then next slide. So first of all, as everyone else has said, working with CDC and their scientists has been a MRESH Europement they've been open, honest, responsive and it's really made our job much easier.

So we have two terms of reference to talk about today.

This one essentially is about how CDC is at the forefront of technology. Technology is changing so quickly. If there's one good thing about the pandemic, it's the advances in technology that actually happened so now how do we take advantage of that and move FWAFRD? And really the key to that is partnerships with academia and industry. And I just love listening to Vicki and ren because you're already doing this so this is really good. But I would like to advance on that.

So next slide, please.

This is just a process. We met just once virtually. We had outside subject matter experts from nah and we talked with Dr. salerno and Dr. McCannell.

These are the challenges.

CDC is a government bureaucracy. That's the sort of bottom line. We understand that.

But we feel that CDC's engagement practices are complex, lengthy and time consuming. They don't really have the resources they need to build the relationships with industry and academia that are going to require funding. And this also is the government approach to working with private industry in terms of one after NOERP. -- another. I think we have to take into account that's the reality.

But the conclusion really was that there are other agencies in the federal government that do engage with academia and private industry in a more flexible and approachable way and so next slide, please.

We use these three examples.

During the pandemic, the nih's radx program made huge advances in dealing with industry.

Certainly advanced the development of point of care and rapid tests greatly which is a huge boom to public health.

barda has ongoing relationships with industry that are very productive and the department of energy actually has very interesting strategic partnership programs that we talked about.

I want to make clear that CDC is already working with private partners and ren gave us a few examples of this. The mou for monkeypox with the commercial labs which was done without resources. And that was something that I learned. I had assumed there was money behind there and there was not. That was really good to know. The spheres collaboration around sequencing was a collaboration with public health labs, academic institutions and the private sector. The pathogen and genomic centers of excellence which was stood up last year, I think, five or six collaborations around the country between public health agencies and they had to have a partner with academia. And at the moment, there are ongoing discussions and work with radx and CDC and one particular industry partner collaborating on hepatitis c elimination so there are clearly examples of CDC doing this already.

This is the one that is incredibly important to me and ren has already started talking about using the term national laboratory system during the pandemic it became so clear that one part of the laboratory, sector of the laboratory industry can't do everything.

Everybody had a different role at a different stage. And so having a national discussion about what a national laboratory system is at both peace time to sort of figure out the roles and responsibilities and then act in emergency is incredibly important and we think that CDC as the premier reference laboratory in the country should take a huge role in building this.

They're already starting to do this so we just really are excited about being part of that conversation. So the proposed action steps, we don't think that CDC should reinvent the wheel in terms of what nih, barda, department of energy are doing but by getting closer to those agencies and becoming a partner in the relationships and enhancing the relationships, we think that CDC can bring skills and access to real life situations that would be very important. We think that CDC should make working with the private sector just an accepted part of everything they do. You know, getting in their dna is such an overused term but that's what we mean. It's just part of what they do in part of the system. The third bullet is a somewhat sensitive bullet. I have to be frank.

CDC's labs have a very core turn around time in terms of dealing with egeteric diseases and whether the laboratories could play a role with the CDC in developing in terms of the rare diseases. This fourth bullet, this is the national laboratory system. This is to me one of the most important things that we as public health community need to do at this point in time and the last one is a bit self serving.

We think that there should be laboratories that are experts on all your advisory committees in the future. Sorry about that but I think it's -- we think it's important. Josh is going to give color and formality and corrections to what I was going to say.

>> I thought you did a fantastic job. Thank you. If there are any questions before we proceed.

>> Why don't we go ahead and if people are agreeable, I would like to ask one of you to make a motion to adopt the proposed ABZ steps that you just outlined as official recommendations from the acd and discussion after that. A motion?

>> So moved.

>> Do we have a second?

>> Second.

>> Discussion? It's really important area that if highlighted in some of your previous work but calling it out in this way is critically important.

>> One thing to say, we appreciate the rfi process that's going to be used for like bigger questions but there should be some mechanisms for engagement that don't require that. Sometimes it appears that with rules and ground rules and structures for them but some ability to be able to work a little more nimbly.

>> I'm wondering if the recommendations should be directed to particular parts of the CDC. If we direct these toward the center, does that provide you wind behind your sails to get more resources?

Just a question.

>> That's a good point. The fact that the acd is making the recommendations to the director I think makes it clear that from a resource perspective, there could be a need to look across the agency. Any other discussion on this? If not, I would like to call for a vote. All those in favor of the proposed motion please signify by saying aye.

Any opposed or abstentions? If not, this carries.

Congratulations, very important work. Thanks to the committee.

And we'll move on to part two.

>> OK. Part two. Next slide, please. So ren talked about recruiting scientists, recruiting staff and this is the focus of this terms of reference. Can CDC better recruit and retain laboratory scientists to ensure high quality advanced laboratory testing and this is basic to all of the scientific work that happens at CDC. This is our process. We met virtually in October. We talked to Dr.

Dr. henning who leads the leadership service to --

excellent individual from the office of human resources, Kelly mathis and Jason Washington, also Vicki Olsen and Wendy cunid and we had a very fun discussion.

Again, the administrative processes are not helping I think is the best way I can say.

The ability for CDC to hire the highly, well educated from very complex backgrounds, scientific staff that CDC needs. Even when technically qualified people are identified, getting them to a job is incredibly hard and the result is a shortage of talent and I think that in the new center, you're going to need the right people with the right expertise and so we have to think about ways that CDC can develop recruiting processes that are appropriate, equitable and done in the right way but that allow qualified scientists to come in because we actually think that this is a vulnerability and outputting work at public health risk.

We feel that other federal agencies that have strong science component are able to attract and recruit scientific expertise in ways that seems CDC cannot and we believe that the office of human resources should work with other federal agencies to look at their practices, see what they're doing and be informed by doing that. We heard that there is not a good career path for scientists at CDC.

There's no logical way that scientists who are really good at benchmark and overseeing the science can progress in their careers. And establishing a career path, we think, is incredibly important.

We also would like CDC to look at the laboratory leadership service program which is an amazing program at CDC, two-year program. Many of the fellows who graduate from the laboratory leadership service stay in public health which is really great but there's a clear qualified, board qualified scientists nationally and especially at CDC that we think that adding

an extra year to the laboratory leadership service should get fellows ready to sit for the board exams would be a huge step forward. We understand this was looked at before and not supported so we would encourage CDC to look at it again.

I want to -- I don't want to be critical of the office of human resources because they are doing their job assuring that all their practices are equitable and appropriate but we need -- we definitely need more flexibility in the hiring practices to be able to attract and retain qualified scientists at CDC.

I'm going to make the motion to adopt the work group, recommendations from the acd.

>> Fantastic. Do we have a second? Any further discussion on this? I just want to quickly add, you've done a lot of great work. This particular one caught my eye as far as pointing out the realities of some of the relatively straight forward steps that in theory are possible and at CDC could take, given that it is a government bureaucracy to actually better make the recruiting system work to bring in the required talent so thanks very much for that:

>> Great work, Jill and Josh. As you were looking at this, did you also take a look at internally for the CDC as leadership is being identified that they're actually providing leadership skill development? I see this often doesn't happen in bureaucracies or in large organizations in an academia. We have a tendency to promote from your history what you've done and not help you to go to the next step and be as successful as you move into the leadership sort of positions which are different from what probably brought you to the attention to get the leadership position which is often our clinical and/or laboratory skill sets.

Just wondering if you took a look at that.

>> I don't think we went into that level of granularity. It was mostly getting people in the door with the right qualifications.

>> I think it's a very good point you're making. It's just the challenges right now are that people who are doing hiring for lab positions are -- can be quite frustrated. You're able to get the applications in from people who they know are applying to be able to interview them.

>> Monica?

>> Thank you so much for sharing these updates and I was just curious in the conversations with the colleagues around the challenges of recruitment and retention within CDC. If you also discussed similar challenges that are happening at some of the largest health departments that have labs and then certainly at the state health departments and was curious about sort of the more enterprise systems approach and recruitment into the field and opportunities for laboratoryians at the state level, for example, to move into the CDC and vice versa. That was one question.

Then second question, having been able to collaborate with other agencies mechanisms that might be available for ipa's or to have similarly trained in the private industry or academia be placed within CDC is another thought. Thanks.

>> So there's more detail in our report of absolute -- of specific mechanisms, fellowships is a really good idea so that academia or private industry can work at CDC and vice verse A.

Definitely that's one. There's specific recommendations also about making sure that all recruitments go outside. Not all recruitments, some of them are at preexisting employees. So, you know, there's specific recommendations there. Your comment about the shortage nationwide is absolutely true.

It's been a huge exodus of public health and laboratory scientists after the pandemic, just everywhere. And so I think we have to use all mechanisms available to get people interested, get young people interested in science and laboratory careers and raise the profile of the value of the laboratory career in young graduates. But they're going to take time to grow so there's definitely a gap in the short-term.

>> Great. Thanks. Great questions. Let's go ahead and call the vote. All those in favor of adopting the motion as proposed, please signify by saying aye. Are there opposed or abstentions? If not, the motion carries and these will become recommendations of the acd.

Thank you.

And now next slide. It's almost impossible to say thank you but I'm going to ask Jill and Josh to lead these couple of slides in preparation for a vote to sunset the laboratory work group.

>> You go ahead.

>> In general, I think we've hit the note about how appreciative we are.

>> Can we get to the next slide while you talk, please? SDPOO here is the fantastic work group representing many different sectors within the laboratory world. We had many productive conversations with them. It was fantastic experience and we want to formally thank them. Maybe I'll just quickly mention Dr. varma, Dr. rhodes, Dr. Wakeman, Dr. patel, Dr. Timothy, Dr. Southern and Dr. toney. It was a great group.

I'm happy to follow on Deb's --

[Applause]

and why don't we go to the next slide. We really do want to thank both John auerbach and Dr. Houry for the shepherding of this process. We didn't really know how to proceed when we started and we got pretty far. I also want to give a special shoutout to Lauren Hoffmann who did a lot of work with us and was there every step, every email, every chance to make sure we

had the correct updated drafts or slides for everyone and just set up and ran everything with perfect precision. We just could not have come together without her.

And also the people whoa came to the working group over the many meetings we had and answered questions. Very candidly. Really helpful and allowed us to put forward the recommendation.

Jill?

>> We just had some great conversations so I learned a lot as much as I hope that we've been helpful to CDC and I hope we can continue some of the conversations. Just thank you to everybody.

>> Great. We make a small joke, if I'm permitted. OK. We may explore creating a virtual Lauren Hoffmann to help us with informal meetings of the group for reunion purposes only. Not for policy making or public purposes.

All right. I think that --

>> Go to the next slide.

>> There's a little tear to my eye. But I have to entertain at this moment a discussion.

>> So moved.

>> Is there a second? All those in favor, signify by saying aye.

>> aye.

>> Are there opposed or abstentions? Motion carries. And all Jill and Josh have just said it, on behalf of the committee, I would like to express our thanks to this incredible working group. I had the opportunity to be part of a couple of the meetings and saw both the group and the CDC support in action and it was quite amazing. And I can't lie.

We can't let this moment pass without commenting on another attribute of this working group and that's the leadership of its incredible co-chairs, Jill and Josh. I think if the term dynamic duo had not been already invented, we would have needed to have invented it for this.

>> Just for the record, I'm robin.

>> Perfect. Perfect. And you two are not done. As we said before, sunsetting and work group because the tor's have been completed doesn't mean that anyone, the CDC or acd thinks the job is done. Instead we're going to rely on you two to ensure the acd continues to hear from CDC on the implementation of these recommendations and identification of emerging laboratory issues as they arise in the future, both consideration of work groups by this committee and across CDC.

So Jill and Josh, laboratory working group, CDC staff, thank you.

Wow. We're on time? Deb didn't think we could get there.

Let's go to the next slide, however, so we can stay on time and we're going to make a change of pace here and I'm really delighted to welcome Dr. Charlene wong to this group.

She's the senior adviser for strategy of CDC. Newly at CDC bringing a lot of skills and experience from a variety of places including the state level near and dear to my heart and she's going to be talking to us this morning about Dr. One of Cohen's priorities, protecting health as a team sport, supporting young families. You have the floor.

>> Thank you so much. Thank you so much for having me today.

Really excited to share a little bit more information about one of our focus areas and also have discussion with you all about how to really move the work forward and have the impact that we're looking for. Next slide, please. So on the left side of the slide, these are the three focus areas that Dr. Cohen has identified for the CDC and she'll be talking about these a little bit more in her remarks later. These include identifying and responding rapidly to health threats which includes our work on the fall-winter respiratory season that we're deep in currently. The second is improving mental health and combating overdoses and the third that I'll be folk used more on today is supporting young families. And within these focus areas, we've been talking about how to meet our mission to protect health and if we didn't know it before Covid, we know it now and have been doing this for awhile at CDC but if we're really going to meet that mission, it's going to take doing it as a team so the frame we've been using is protecting health as a team support. We've been prioritizing that collaborative approach because our goal is to accelerate impact on these important areas by bringing our teams in public health alongside team meets in health care, social supports, public and private sector, academia, you name it, we're interested in talking about any and all team members who can help meet the mission and help the populations we're all trying to serve.

And as you all know, working as a team means a couple of things, right? First is we want to make sure we're building relationships and identifying aligned priorities with our partners. We want to think about how we can also identify what our shared goals are so that we can share the accountability with our federal as well as our state and local partners. And today I'll be talking more about how we're tactically moving in this way by developing a set of collaborative initiatives to really model how we at CDC and public health do this work.

Then of course, another critical component to protecting health as a team sport is also coming together to tell the story of the successes and impact that we've had. I'll add as you look at these three focus areas on left side of the slide, these are obviously tricky, complex, hard things to tackle and let's be honest, in areas like mental health and maternal health, we're not seeing things move in the right direction and these areas there are so many different parts of our public health, our health care, social support, community eco systems that need to work together to move in the right direction and so, you know, it's in these three areas we're focused on the approach of protecting health as a team sport.

On the next slide, as I mentioned we're move to go action and tactics through the set of collaborative initiatives. These are existing cac programs, policies or data activities that can accelerate impact on major public health issues by leaning into results based partnerships and I'll talk more about that in a second and increased partner engagement. We really started a lot of this work and we said aligned priorities by talking with our colleagues at the federal level to say, you know, where can we showcase our joint leadership and our joint priorities to find areas that we really want to lean in together and say, we can make a difference. We can demonstrate measurable impact in the next nine to 12 months together by decide to go really, again, prioritize and lean in together. All of these collaborative NISH TICHs --

their initiatives have been refined with cross agency input and many of them really build upon collaboration that's happening across cio's within the agency as well.

And these all build upon, as you all know, the many established partner public health activities that have been ongoing at CDC for a long time.

On the right side of the slide are some icons of some partners that were identified by cio's and that we're continuing to lean in deeply with in this work.

I know you all have heard about moving forward and you're probably maybe already making this connection in your mind but certainly these collaborative initiatives and this approach of protecting health as a team sport are aligned with multiple of the improvement areas identified through moving forward. One very obvious one there's a section called results based partnership and so the blue box at the top talks about these are words from, you know, our moving forward plan which is about promoting results based partnership through partner engagement and partnership best practices and a couple of the partnership best practices that we've really been implementing through these collaborative NISH TICHs are things like again, aligning on strategic priorities so it's not just we at CDC taking we think that maternal health and working together to improve maternal health is an important thing. We're also identifying it with our partners. They also have identified maternal health in some of the specific strategies as a top priority for them.

And it's going in addition to identifying these strategic priorities, it's getting tactical and saying how are we going to collaborate and coordinate our efforts on a work plan? And then being very up front about stating, what are our goals and how are we going to share accountability because we stated these goals together?

So now on the next slide, I'll go a little deeper into the focus area of supporting young families. As I mentioned, we've been identifying these collaborative initiatives within the focus areas.

So when we talk about supporting young families, and I'm a pediatrician on I love all the focus areas. I really love this one. It's really about prevention and prioritizing upstream. As far upstream as we can get because we want all kids and families to have the opportunity to thrive the way that we've talked about is when we talk about the centers for disease control and

prevention, this is the capital p, the prevention that's actually silent when we say CDC. And so today what I'll do is I just want to give you three different examples that really are great opportunities to describe this type of work and also the reason in particular supporting young families as well as mental health and in the respiratory season that it's so important to work across sectors. When you think about the different parts of our public health, health care, our community eco systems that are touching and working with children and families to support them, there's a lot of them and so there's a lot of opportunity to really think about what can we in public health, what's the role we can play? What's the role that CDC can play specifically in helping to bring that coordination and collaboration to our efforts?

And that means that the federal level as well as at the state and local levels, there are complexities to the way the systems work.

So we're really looking to break down silos. I want to give a story quick. Families that I've seen in my clinic, you've got a single mom who has her infant with her. I'm talking to her about tracking developmental milestones and it would be great if you got signed up for wic and don't forget, we talked at the middle schooler's last appointment, he's missing a lot of school. We should address that and what that means for real kids and real families is her to-do list coming out that far visit where we're trying to do all the things to support young families, it's too long, asking her to navigate a bunch of systems that frankly don't work particularly well together.

I give that story because for any of us that have worked with kids and families, this is such the common occurrence as we're trying to support them so all of these are with the thought in mind how do we make it easier and more likely to happen that kids and families will get the support they need.

All right. So let's go through the first example. I'll fist describe what the collaborative initiative is and why it's important in this moment and then also I want to highlight that shared accountability piece and how we've been talking about measuring and really driving forward that result based partnership. So for this first initiative, which is learn the signs. Act early. And I see Dr. remley in the room here.

This is coming out of her center. Since Covid we've seen a really concerning rise in the number of kids who were just missing developmental milestones and certainly this is feeding in to the youth mental health crisis and many other issues we're seeing with children currently.

So CDC has a fabulous online basedly to called learn the signs, act early. You can go on your phone right now and LOUN load it if you would like. This is a tool that families or child care or health care workers or really anyone can use to help them identify developmental issues earlier. As you all are likely aware, the earlier we identify the issues and get the kids linked up to supports, the better the outcome. So to meet this moment where we know we have more young kids who are missing these milestones, we're working with partners to super charge dissemination and use of this free, ready to go evidence based tool. It's things like working with hrsa to work with staff, we're working with the administration for children and families because

they want to help us get this into the hands of more early care and education providers where we've had huge turnover during the pandemic and we've just got a lot of folks who are working with kids who BHA not know what some of those developmental milestones at 18 months or two years might be.

We're working with usda at our local nutrition partners through wic programs who are interacting with the families.

They can also be sharing this really great tool that any family can be using or they themselves can be using to say hey, your kid is nine months old. Did you know this is what they should be using and if not, why don't we get you hooked up with services. You can see some examples of the types of metrics that we've identified and if you can go back one slide, that is really promoting results based partnerships so really measuring and sharing with our partners, we want to see an increase by 25% of use of the tool because we know that this is the type of thing that can help families and can help young children.

We want to track the number of the fqhc's we're partnering with using this type of tool over the next nine to 12 months. So next slide, in another example that is both supporting young families and also overlaps with that mental health focus area, we're excited to be co-leading work on expanding the implementation of positive childhood persons strategies. Also another way this is often talked about is preventing adverse childhood experiences. I think as you all know, aces are associated with all the bad things we don't want for kids and more of them they experience, the more likely it is that they have poor health outcomes. So on the left side of the slide, you can see a screen shot of a wonderful resource for action that we have at CDC. And this collaborative initiative is all about partnership so that we can bring more of the strategies that we know work that are in this resource for action to life with our partners for more kids and families so here we're working with, again, the administration for children and families and the minor academy of pediatrics as well as the office of the surgeon general to prioritize of the strategies and resource for action, we're honing in around things like strategies that promote social connectedness for kids and families, things like parenting supports and bringing those strategies, not just saying here's a pdf we're going to email to you but deeply engaging with partners together to say, hey, we want to make sure you know, these are some of the types of things that could be brought to your community, your daycare center, you know, all the different places and we're here to support you in putting THEEGZ -- these things into place.

We're leveraging networks and grantees across the agencies. We just met yesterday and we're sharing the list of grantees we think will be best suited to cross share information. And we're also taking advantage of this particular initiative because as we talked about shared accountability, we all recognize there's an opportunity to get even better measures how we measure things like positive childhood experiences and social connectedness so we're working together to say how can we leverage this opportunity to get some of those measures?

And we are thinking about sustainability and leveraging, something that David we talked about as we think about doing this work, right, it's with the partners, specifically, as well as leveraging enterprise wide structures, in this case the HHS has a behavioral health coordinating council that Dr. Houry is very involved in and we're using that for capturing some interagency collaboration and lifting up of this work.

And in the final example on the next slide, I'll talk about some of our work to improve care for postpartum women. Again, you all know this is a top priority and with multiple priorities at HHS and beyond, we've identified the postpartum period as a critical opportunity in particular for working with states and local jurisdictions and we at CDC with the partners listed at the bottom of the slide have honed in as hypertension as the major cause. We have ihs and tribal partners because we're meeting with equity that's another topic for discussion today because we know that rates of hypertension related disorders in pregnancy are much higher in the tribal populations and we've been working with them to listen, to say what is it? We've got great things coming. You can see the milestone. We have a hypertension in pregnancy package that's forthcoming and we listen to say, what from this is going to be useful to you?

What other things might be helpful to you all as we think about supporting aian, PREG NAENT people and their journey particularly as it relates to hypertension and highlighting we've got the process metrics and working with folks like sms to say, what are the payment structures and mechanisms to support more of this kind of work where we want to bring more self measuring or self monitoring blood pressure cuffs into homes because we know that's going to help people be able to track their blood pressure and get it under control faster.

So to close on the last slide, I'm just giving you today three examples of collaborative initiatives that are about supporting young families at CDC and supporting young families space, we also have other collaboratives that cover immunizations and school based reports for behavioral health and I just want to highlight how this work is really promoting results based partnership and our work at CDC to be part of an integrated system that protects the public's health and this is really about building partnership as a core capability at CDC.

So as we move into the discussion, I did want to just say that hopefully you've seen in these examples these initiatives are in many cases about inspiring action and bringing more public health data and best practices to life in more states and local communities and so we would really value your thoughts how we can most efficiently and effectively work with health care systems, payers, other community based partners who in many cases, they are the arm that will bring these things to life like sometimes it's our role at CDC to say, hey, these are evidence based practices that would work and we need to find the partners who are in the best position to bring those things to life. We would love your thoughts on accelerating implementation with these partners and then also with this esteemed group on the acd, think about evaluating the efforts or generating more evidence on how we bring more of these to implementation, thinking about, for example, implementation in science on these type of collaborative efforts.

>> Thanks very much. It's really important work. We have about 20 minutes for discussion and would welcome input on the issues that Dr. Long highlighted or other issues. Julie?

>> Thanks for your presentation, Charlene. That was really helpful and very clear. I love this concept and it's so nice to see CDC partnering with other federal agencies. I feel like that's an area where there's a lot of opportunity that's been unrealized in the past so it's exciting to see this. I also like the fact that you can see you're focusing on marginalized populations in a lot of the work with your partnership with hqhc and wic. The metrics you identified didn't necessarily get into tracking the uptake of the different groups. The way we ensure what they need is tracking data by their populations. I was just wondering, is that something that you're planning to do?

>> Yeah. Julie, thank you so much for the question. Certainly something for some of the collaborative initiatives where those data are more readily accessible, I think that is one of the challenges we have for many of these types of initiatives and again, I'll look at Dr. remley as we're tracking, for example, use of that great online based tool, harder sometimes to be able to identify who is actually using it. That's why we're really leaning into and I will just say because all of these were proposed across cio's, one of the fantastic things as they came, in they were all leading with equity.

So working with wic, working with fqhc's, we know we need to make intentional efforts but I think the measurement piece can be more tricky for some. For some of the initiatives, we have been talking about using, how could we leverage other data sets like Medicare claims data, for example, when looking at hypertension to say, well, we do know some additional socio demographic information and how can we use those to see as a proxy where we think we're getting more of the uptake and several of these are very much targeted at addressing the inequities and disparities we know exist.

>> Work our way around the table here so octavio.

>> I'll get it later. SHAU for that presentation. Love the approach with the aces, obviously. As you were talking about support for parents, one thing that crossed my mind, and I wondered if you've considered this, we don't think about the parents of the children. Giving the trends that have happened he is essentially with the opioid crisis, we're seeing a greater number of older adults, grandparents raising the kids, right? So ensuring these resources are also addressing all individuals who, in fact, are raising kids, I think it's relevant for rural America as well so it would be important to ensure the marketing of the resources takes into consideration, taking that nuance to get to those kind of families, structures and especially in rural America. I wonder if you had any thoughts about that.

>> Thanks. I already got distracted by the song. Thank you for that question. Yes.

Actually, Karen and I are like giggling at each other because we've been talking about just that. Multi generational approach to how we support young families, 100% so important. I think Julie

ties very much into your question as well because we think about the households where there are broader multi generational approaches, it's historically in the marginalized populations. 100%. We could even think more deeply about opportunities to engage some of the other partners to make sure that we're reaching those populations.

>> Excellent. And a separate question, postpartum care, super important time frame when it comes to children and their development but any thoughts about preconception? We're talking about going upstream, I think when it goes upstream, it's possible. As a pediatrician, the eco system that exists prior to even conception that then actually results in how a child is to be raised and what kind of factors are going to impact them, especially those aces, just wondering what your thoughts are about that.

>> I'll say that as we're thinking about the postpartum period, part of the reason that came up is because we're thinking about often a longer postpartum period. One of the discussions we've been having in HHS is to say when they by about the possibility levers, where is the opportunity to go after something? We now have 37 states that have extended postpartum Medicaid coverage for 12 months.

PRACH --

As you know, that extension doesn't necessarily mean we get the medicine to those that need it. Now that so many millions of people have access to that extended coverage, it's a nice use case to move from maternal care to primary care which for several of you folks has never been available which will also lead to interpregnancy spacing, preconception. We were certainly thinking that as the whole spectrum really of like postpartum from this pregnancy and potentially leading into a healthier next pregnancy but also I think lots of thinking about preconception and again, everything is about getting very far upstream.

>> That makes total sense. Even Texas we finally got the legislature to extend postpartum care through Medicaid for the full 12 months after.

>> It's so exciting it like so many of these, just because there's been a policy change or best practices guidance released, it's how do you bring that to life, how do you put it into action for people? That's what we were thinking about with this one.

>> I was trying to focus on what play list Josh is curating for these. So I got a little distracted myself. Thank you for walking through the three priority areas and just really excited to see how your state experience is infused throughout all the work that you described.

My question is related to the health equity work group and the recommendations we've developed and I know you started out by describing the different partnerships across the flips, you started with health care partners and then community. Can you talk more about how equity is embedded in the three agency-wide priorities that you described, number one, and number two, the followup is, how you're all thinking about community engagement and

partnering with communities in developing all the work that follows and also the measures that I think Julie described.

>> OK. So I think, you know, I came with Dr. Cohen from North Carolina where our friend there, we lead with equity. We all lead with equity and so certainly I think the three focus areas that have been identified have been identified leading with equity because in all three of these areas, we know there are intense disparities and this work of protecting health as a team sport, like I said, it's about bringing strategies including those that help address the disparities so we're not just admiring the disparities, we're working to bring things to action to address them. I would say like in general, 100% all those three were identified with equity in mind.

I think your second question about community engagement and this is at a good example of the measurement. Let me give you an example of one.

We're thinking about how we take the collaborative initiative opportunity to build a process that we can use every single year that's related to fall/winter respiratory season and it's really our new rsv immunization products to protect infants. rsv is the leading cause of hospitalization for babies and our American Indian, Alaska native babies have a rate of hospitalization four to ten times higher and there's also a unique recommendation for them for the infant immunization we've been working with aap and tribal partners and a number of people on to get the right coverage is we're actually just now kicking off a process that can be a yearly thing. As we get through this respiratory season, we're going to start right after with listening sessions and we've identified the tribal partners who are going to help us to, you know, find the folks we want to listen to to say, OK.

We just came out of this respiratory season. What went well? What didn't work? What is needed? What sorts of questions were you getting from the community? What sort of misinformation were you hearing from the community? We do that early in the calendar year. Then we take the next couple of months to together very deliberately and with time, do the work that we're aligning on what's our messaging for the next season? What sort of resources do we need to develop together so we're really lined up by the early summer so that when we need to launch the next season of support and communications, those pieces are in place.

You know, that's just an example. Then Julie, to your question, that's one where we've been looking at and we do have some of the socio graphic information so we can look at the social demographic groups and we can work in getting more granular and how quickly we can see and visualize the data so that's one example.

I appreciate the question.

I think there are others in which we can think about more deeply doing but I think this is a very nice example we're just kicking off now, actually.

>> So I definitely think --

thank you and also probably on your radar but in terms of partnerships with other agencies, through hrsa and the healthy start initiatives, when I was with the city in Boston, we had a very active -- and Julie is nodding, too, in Chicago a community advisory board. So not having to reinvent the wheel, appreciate that and just leveraging and activating the community advisory boards and others.

>> And this is part of the work to develop these. There she is.

Her team presented on some of the -- to make sure all the cio's are aware of the groups and to make sure over the year, we will want to be bringing some of these to them. You said leveraging existing groups and even for the tribal work, we're working with some of the sister agencies that have some of these groups established where we're going to be bringing these to them. Yeah. Exactly. Thank you.

>> Well, I think Monica and I think very much alike. I was going to ask a similar question.

I will make a comment. I'm delighted to see the three focus areas, delighted to hear about your approach, the holistic approach and looking at the community eco system. One of the things that struck me in terms of partnerships as we think about mistrust, distrust and you're going to be efforting in critical areas, I think, where that is rampant among different groups, whether it's people with disabilities, and so forth, I didn't see any organizations that have the trust of some of these communities so from the naacp to others who have been in the trenches, advancing health equity so I want to get a sense of how you intend to include groups that represent these racial and ethnic minorities or disabilities and other groups.

>> Such a great question. I think certainly in our work where we're focused on, for example, our American Indian and Alaska native, more of that is built in currently. Let me take that back to the teams. I know certainly some of the partners we're working with, it's all about leveraging each other's network so for example, in our work around aces, part of what the work has been in the lists we just exchanged yesterday, they are local, community based groups that have that trust.

So we're talking many of the icons are federal and national organizations.

Everything that I talked about today, all of that is getting effectuated so working with grantees who are the folks who have those trusting relationships but I think it's a great thing to bring back as we really think about the implementation and support on these and making sure that we're really being quite intentional that we have, in fact, engaged those groups.

>> thank you.

>> Jill?

>> So thank you very much for a great presentation. There were two pieces of information that came up very recently and one is the decrease in childhood vaccinations. Second one massive increase in home schooling. I mean, it feels like those are two things that are going to be a

public health crisis really, really soon. You know, increasing home schooling is going to, you know, they won't meet the school needs and just interested to know with your community engagement, with your engagement in tribal communities, the messaging that we're using.

>> Yep.

>> Something came up at dinner last night about vaccination and are people objecting to the vaccine or are they objecting to the mandate? And it's just something that I think we need to include in that discussion because I mean, in terms of healthy families, the VKS nations are not just for the kids but the parents. This is such a huge area we need to wrap our heads around and just what do you think?

>> So, so many things. Thinking so many things. So one of the collaborative initiatives that I did not talk in more detail about today, we actually have one that's on catchup vaccination for children and their routine vaccinations because it is a huge issue and I think as you raised with the increase in home school, I mean, even the number of exemptions that just came out, it's alarming. So we do have a wonderful campaign that is at the center of this collaborative initiative called let's rise.

Perhaps some of you are seen it.

It's all about partnerships with health care providers, with education. I do think, you know, data we should really be looking at making sure we've got those other groups as well that are reaching out and it's an initiative and campaign that I'm still learning more about but just to say that in and of itself is at the center of one of our collaborative initiatives. Just for your awareness, I don't know if it will come up in this meeting but as we think about schools and the many challenges we've seen there, another one of our initiatives is school based behavioral health supports because we also know that kids who feel connected at schools, it's such a protective factor and also likely to keep them in school if they are, in fact, feeling connected in school and then in addition to that, you all may be aware that we have recently launched our newly merged division of adolescents and school health in the chronic center and leveraging that as an opportunity to look at our strategic priorities as it relates to work to support health and children and schools, both physical and behavioral health.

>> So two -- well, one comment and one minute question for you, Charlene. The comment is that I really appreciate how in this set of initiatives you are saying it's not just about what CDC does directly but CDC can focus on the goal and bring people around it and I think it's initially having you and the director behind these demonstrates the authority that CDC can have even for things not under direct control and leadership force and it's like state and local health departments. Sometimes they're just programs that are run like you may run a home visiting program but that's different from saying let's get people together to lower infant mortality or achieve a public health outcome and I think it's great for CDC to be doing that and that leads me to my question.

As you think about that, are you thinking about the structure that you need for a successful intervention so that it can be replicated across other issues and perhaps eventually across the agency so that it can adopt this or for other things where it can -- you know, different parts of the agency, maybe there's a part of the agency running a grant program for something now but ultimately, it really needs to be thinking about the outcome and working with partners in order to achieve it.

>> Yeah. Josh, thank you so much for the question. So yes.

Definitely I'm thinking about, you know, what sustainable structures are needed and particularly because this is so aligned with moving forward in results based partnership, we're leveraging work that's been ongoing so I'll give you concrete examples.

As we're thinking about that results piece and that shared accountsability, we're lining up the way we're measuring and this reporting is happening with the Ance management framework being put into place as part of the work of moving forward.

Also a big part of this as you all know is building and sustaining relationships, following up, you know, with the actions needed, making sure that we're coordinated across CDC, if we're all reaching to cms and asking them all to do different things or pay for different things with us so one of the things, for example, that's an infrastructure piece that's being built as part of moving forward is a consumer crm, basically the online tool to be able to track, you know, which partners are we working with, who is working with them and so like those types of pieces that are part of the sustainable structure.

I think we're also working with teams particularly in the office of policy, performance and evaluation, oppe to really think about like Monica's we're developing the processes like we talk about, about how do we document some of that process so it's more plug and play across different types of topic areas.

So 100% things we're thinking of and now getting into the phase where we're really starting to implement and build those things so thanks for the question.

>> Thanks for a second chance. I wanted to build on Monica and Daniel's comments because I think especially and also on Jill's because the child immunization is another area where I think this concept of partnering with community is going to be essential. I think if we don't take advantage of the lessons we learned through Covid in terms of the power and the impact and the partnership with trusted forces of information, trust in community organizations at the national level or the state or local level in terms of the ability to actually decrease the health and equities and disparities, I think we will have lost an opportunity. So I just feel like I have to say that again because you guys said it but I feel so strongly that this is critical, it should be as you're looking at these kind of partnerships, with federal agencies and other national organizations, also not forgetting about community because community is so important.

>> Yeah. Thanks so much for that and like I said, this is one that I'm still learning a little more about but I'm quite sure that that is already built in and I think from all of your comments, we're going to take another look at all of these to think about again, where could we potentially deepen.

>> And I want to acknowledge I think you told us you've only been here two months, right?

>> Maybe like four.

>> Just very quickly I know we're going to go just a couple of minutes over, great questions. I just wanted to put one more thought, particularly relative to your request to us to think about how this all comes together at the front lines and you had a really nice story about a provider. One of the things you identified that is absolutely true is that there's fragmentation at the federal level, siloing some of this and you're certainly working to break that down and as you know, but I need to ask the question, at the front line level in delivering services, there's also fragmenting and siloing across the different interventions. It's the same individual, the same mom, the same kid that needs to benefit multiply across all of these.

I'm wondering, have you had a chance yet to think about what you, CDC, the federal government might do to actually help integrate thinking about the range of these interventions we're talking about so that those front line community based organizations or community health workers or providers can more quickly identify and assure across all these interventions that the ones that are most important are the ones that are actually getting delivered?

>> So yeah. Thinking and appreciate you all's help in thinking because obviously it's an incredibly complex and tricky. I'll give two thoughts on that. I think one is that certainly in health care and other sectors, things follow the money and so one area that we have been working with in a federal partner that we've been working closely with is cms as we think about what are the payment structures to bring public health, health care closer together and how KT payment structure support more of that. I think that's one area. I'll give one example where it is -- to your question, I think what you just asked which is, we have limited intervention resources. We want to make sure we're matching the right intervention resources in the right places and for the right people. One of the collaborative initiatives that I didn't talk about today, it's in the mental health and overdose space is in the overdose and overdose stated action space so we're working with samsa to say, you know, we at CDC help support incredible public health data and best practices related to overdose and the overdose data action program, dollars going to states and jurisdictions.

samsa does the same thing.

They fund with treatment. In some cases it's happened organically. They have connected the dots at the state or local level and they bring those data and those resources together so they're bringing the limited resources to the right places or best places. We're working with Samsa to say what can we do together so it's not crossing our fingers and hoping that

organically happens at the local level. We're doing collaborative work with our state and local grantees so that that type of dot connecting, we're helping drive that so that we're doing more of that matching.

But again, it's such a great question. I think these are like pieces of it but when you think about like the fuller spectrum and how the different pieces from public health and health care come together and how you prioritize it, I think all things still being worked on and certainly we hope through this work and the protecting health as a team sport and these collaborative initiatives, it helps us build processes, muscles, tools so we can continue to further the work to get there.

>> Thanks very much. Thanks also for taking the time for that great stimulating presentation.

We really, really appreciate it.

And we're on break and we're going to go ahead and take the full ten minutes that we were allotted and reconvene at 22 after. Thank you.

>> We can go to the next slide.

We have an interesting and important session now and a great person presenting it so I would like to introduce shsherri berger talking about some decisions that have been made on what programs have been affected as the Covid supplemental funding resources have declined so you're on.

>> Great. Thank you. Hi, everybody. I think I've met everybody at some point in my life. I currently serve as a senior counselor. I've been at CDC for just over 27 years and I have one month left and I will be departing the agency so I was given the privilege to talk about my favorite subject here at CDC which is the budget. I worked on the federal appropriations process for many years before serving as chief operating officer. I tend to speak too quickly when it comes to budget.

>> It's a little soft, too.

>> Eye never been told I'm too quiet so that's good. We'll go through the slides and then do we do questions at the end? Is that how we do this? Wonderful.

I was asked to talk about the KFD recision which is drew by the fiscal responsibility act, fra. This bill did result in a recision or a returning of Covid supplemental funding from CDC.

Of course it was across the federal government but I'm only going to talk about the funds that were provided to CDC. So one question that David and I discussed when we were going through these slides is no, these funds did not address what had already been obligated so if a state or local health department, public health partner had money in hand, if they had not yet spent that money, meaning they hadn't used it, those dollars were not rescinded. I would say what was rescinded is money at the government bank that was not yet obligated. All of these dollars had plans. They just haven't been obligated so in some instances it might have been a multi year grant program and we were putting out -- I don't know -- let's say hypothetically $200,000 a year for disease intervention specialist program for tracking down std cases to improve our work force for contract tracing. Maybe we worked three years and we had not awarded the second two years. Those are the dollars that were rescinded.

The other thing the bill does that's nothing to do with Covid, it actually puts spending caps in place and I'll talk for a second about that at the very end. Next slide, please. OK. So how much money came to CDC? So CDC received two sort of buckets of Covid supplemental dollars.

First was saying this money will go to CDC for and that was just about $27 billion. The second bucket was money that went to HHS and it was either for public health work force or it was for something called testing and mitigation. Those were the two really big buckets of money that resulted in about $55 billion intended to come to CDC to be obligated over a couple of years. Next slide, please. In case you need it and you probably have access to the slides, did I -- I did give you details to each of the bills and what came through HHS for all the supplementals. You have access to it if you need it.

Next slide, please. OK. So what were the impacts? What Congress did in the fra was rescinded buckets of money from CDC.

Basically they said balances for these following lines would all be returned to the U.S.

treasury. First bucket was vaccine distribution and related activities and these are the labels that Congress uses. The second bucket was for vaccine confidence and the third bucket was for our global health activities. The good news was that a lot of our other keep priority areas like data modernization and gemonic sequencing were not impacted because so much money was in a pipeline or Congress worked that work was always intended to be multi year money for infrastructure so those moneys were not rescinded. So here at CDC, this was the approach that we took once we received the final word which was, we had to make some tough decisions. We had to go back through all of our approved spend plans and figure out what needed to be stopped completely, where we might be able to do some of the work but not all of it and where we were able to potentially use other Covid dollars or base resources to continue our commitment and that process took longer than many jurisdictions had hoped. I think they thought we were going to have answers overnight and they had been waiting for months for answers but we did work through the process. It does take time and we work through the administration so spend plans are drafted at CDC, they go through HHS and are delivered to the

White House office of management and budget before we're able to execute on the dollars so the process does take some time.

These are examples of programs that either ended completely due to a lack of funding like the disease intervention specialists or we had to scale them back like the public health and Americorps. I provided a list of programs for you. I can explain about what some of them are. I think you probably would be most familiar with the first bullet because that was in the press. The money that was to go to the jurisdictions to modernize, not to run these systems but to modernize the systems was rescinded.

The next two bullets are really about outreach in education about vaccines to increase vaccination rates and to address some of our challenges around equity and those dollars were rescinded.

The next couple of bullets were really about the work overseas, building the capacity to do better surveillance and early detection of Covid around the world, disease intervention specialists, we talked about.

The laboratory data exchange program is really exactly what it says. It's about improving our ability to get lab data from jurisdictions and labs around the country and then public health Americorps which is near and dear to my heart. We were able to start with Covid dollars but after next year, there will be no more funding for that program. Next slide, please.

SOEK. And this, I don't want you to worry too much about the numbers because they're going to change but the bottom line here is that fra did not just impact Covid but put spending caps in place and we have seen the house come out with its fy24 mark for CDC and it's not great. The house mark was obviously much better and there will be a couple of weeks, if not months of work and, you know -- house came out. It was not great. Sorry. Did I say house? Keep going. House mark was not great. Senate was better. We are under a continuing resolution on maybe the cr will be extended a few more times before there's finally a negotiation between the house and senate but they are very far off in the bill that we sit in which is the labor HHS and education bill.

They are very far off so it's going to take some time.

Our bill is typically one of the most controversial and it looks like they'll take some of the easier bills off the table and resolve those sooner and I think ours will probably be closer to the ENTD -- end of the batch. I tried to do that as simply as possible. That's the last slide. I wanted to leave room for discussion. Thank you.

>> thanks. Great presentation as always. Open for discussion, questions, comment. And while people are thinking, I guess I would like to ask, you know, Covid did result in a fair amount of resource both coming to CDC and the state and local health departments and as a result, they were able to do new things. Sometimes in a budget cutting environment, when dollars go away, it's last and first step and argueleuably, it can being argument going forward.

What can the CDC do that enables, as budgets are reduced, let's look at what's most important to keep, not what was the last thing to put in and the first thing to go out.

>> I think that's great. You might get five different answers to the question so I'll provide my personal perspective which very much matches the appropriation strategy we've been taking over the last couple of years which is, where can we invest in public health infrastructure that will lift up all of public health. For me that is work force, that is data, that is lab capacity, that is readiness and response and that is the global health portfolio and I think that holds true with the Covid investments we've been able to make.

We have $3 billion that went to state and local jurisdictions and grant, about 110 recipients for public health work force. It is important to continue to learn from those experiences to hear the successes of those programs from the jurisdictions directly because at some point that money will be running out and our hope is that we can educate members of Congress about the fall that that program added to their public health infrastructure and their own state or local jurisdiction so they will want to continue that and the same holds true for readiness and response for laboratory capacity and especially for data. If you look at the projections and the work that Jen has done, we're looking at a 10 to 12 billion need for data modernization over a five-year period. We're able to chip away at that with the one time Covid supplemental but we need to articulate what we were able to accomplish in a very short time so that Congress sees the value of the money and wants to make investments even during tight times.

>> This is a shy group today.

I'll do one more and then we'll see if we have questions. This may be unanswerable but sort of a frustration that I have and it has to do, you use the data modernization example with the need for long term investment, in order to make that happen, oftentimes, particularly sitting at the state and local level, the request is, well, in order to make investment, we need permanent funding. We can't use one time funding to make an investment. Yet we live in a federal system that doesn't provide permanent funding. On the way out the door, what creative ideas do you have for resolving that inherent tension?

>> Yeah. I mean, if I were given a blank slate and the opportunity to solve that problem, I think this particular challenge is not going to be solved with discretionary funds.

It's impossible to get what, 12 billion dollars in discretionary funds. If I were queen for a day, I would look at mandatory funding source. This problem is not going away. When you look at the hospital system that invests billions of dollars on ehr's, we haven't made that investment here in the public health infrastructure yet and I think that would lift all of public health and I don't know how it's going to be fixed with discretionary money. Not in the spending cap, you know, world that we live in today. That's my creative solution but I'm not sure Congress would agree with that.

>> Be sure to tell them that before you leave

>> Maybe it's easier for me to tell them after I leave.

>> We'll start this way, Joel.

>> this is going to be hard. Go ahead.

>> Just to followup on the point about, you know, one of the challenges is that there's an issue of the moment and then the funding comes in for that, like Covid being obviously an enormous one and a loft funding coming to CDC and then suddenly it goes away. Is there, you know, do you have any perspective on how those mini surges of funding can be used to build overall capacity or is that like a fool's errand to think of it that way?

>> I think I probably asked the jurisdictions but I think, you know, because at the end of the day, that's where the bulk of the resources are going. I think inside CDC there are infrastructure investments that are needed so it's not completely a fool's errand and I think there's an opportunity, for example, moving from on-print to the cloud. There are infrastructure investments that are one time, maybe they take three years to get there. It's not completely outside of the realm of possibility but I think memories are short, you're right, and super, you know, sad to see things like public health and Americorps go away when I thought this was the future of the work force pipeline. I think there's a gap in understanding what public health is. There always has been. There isn't the same level of advocacy that exists in other parts of the government and I think if we could bring together the various KAISH you know, we have so much competition within public health about what's most important rather than again, this idea focusing on the infrastructure, the capacity to build date arcs to build the work force that will benefit everybody. If we can just coalesce and get that message but we need champions again. It's been years since we've had champions on the hill.

I know it's a tough time. I don't think we're going to get a lot right now. I think we need to get through a little more before we get there but I think we need to educate people and public health sometimes is just misunderstood by certain parties what we're trying to achieve.

>> before we go on, Rachel, welcome. I'm sorry I didn't see that you arrived before. We want to welcome Rachel harden to the committee. Would you mind declaring a conflict of interest?

>> I am Dr. Rachel harden at the university of Minnesota school of public health and I don't have any disclosures at this point.

>> Thanks. Monica?

>> thank you. Thanks for sharing those updates. You know, on the beginning slide you talked at a high level about some of the funding that will be returned and it struck me that vaccine distribution and vaccine competence is the bulk of it.

Almost a billion dollars right there. And when I think about even the comments that you've shared about public health infrastructure, some much us have been in conversations outside of the acd debating and reflecting on is it public health? I'm looking at Julie. Is it public health or is

it the public's health? If you could indulge me because then this is related to conversations earlier about vaccine uptake generally being -- decreasing for children's pediatric vaccines and this challenge want just for CDC but for the field around rebuilding, if we even had the trust of the public and really addressing the public's health and so I wondered, not knowing how the agency sorted of how do you respond when you're having to return this large and maybe it's not a large amount of funding for the CDC, how to mitigate the negative impacts and how to mitigate what will be even more barriers in terms of the work that are in the agency and public health departments in collaboration with communities.

How do you go about that? So if you could just say what you're able to say and share.

>> Really good question and it's super complicated and I will not pretend to have all the answers.

I can give you my perspective on a couple of things and they feel interrelated and I think they are right now but the -- let's start with just public health and understanding. The term public health, you're right. I think it's complicated for some people to understand and I have been in circles and heard through the years, it sounds like you're just creating health care for poor people, right? So we have a lot of education to do on both sides of the aisle of what we mean by public health and to your point, is it public's health? That's why when we talk about public health, we try to talk about health security as another way of framing public health for certain audiences because that's ideally what we're doing is protecting and not -- anyhow, I'll just stop there. The second part of it, I think you've all probably received the email but today, Kaitlyn was highlighting the decrease in immunization right now which is a huge problem, particularly for children. There are many successes during Covid but one of them was building an immunization infrastructure for adults. There's vaccines for adults and if you don't know about that, I hope you can read and learn about it and talk about it with your constituents because I would hate to see the infrastructure that was built through this process to basically disappear and the next time we need to have this, because there will be a next time and we all know that, we have to start from scratch again. So it doesn't resolve the equity issues. It doesn't address all the concerns but it helps an ability for those adults who want to be gonized --

immunized to have vaccines. It's trust in the government right now and I would say the top thing our director is speaking about so I'm going to let her answer that question in her remarks. She's much more eloquent than we are.

>> I don't have a question. More just the comment. I think there's nothing like a budget crisis to really force you to look at inefficiencies and ways to become more efficient and I look at your -- the setup that you have with the office of laboratory science and safety and also the office of -- you covered up Jen's highlight.

Office of public healths data and surveillance.

>> and technology.

>> And technology. Those overarching OCHLSs really have the ability to look across the agency to see what inefficiencies there are so it may require investment up front in terms of doing an assessment and defining what the redundancies are but I think this is the opportunity to seize and move forward with reducing those inefficiencies and systems are less expensive and more efficient and just a comment.

>> Those are great suggestions.

Thank you.

>> Thanks, Julie. And thanks for your service with this agency.

We're going to miss you. OK.

Well, it's my pleasure and privilege now to welcome Dr. Mandy Cohen who CDC's somewhat new adviser. A short story by me. I live on bainbridge in Washington and we have lousy cell phone service there so we're one of the few people in the country who has a dedicated land line. Back in July by land line rang and because approximately all of the calls that we get on it are robo calls asking for money, as usual I just ignored it. About an hour and a half later, my wife snuck up in my office and said I just checked the phone messages on the land line and the new director of CDC called and she said she just wanted to say hi and if you had an opportunity to call her back, she would love to talk with you. So I did have an opportunity to call her back. I called and within two rings, she answered the phone and we proceeded to have just a great conversation to get to know each other a little bit, for me to hear about her first bit of time in the office and some of her priorities. And I know that you have reached out to many of the other members of the committee to do exactly the same thing SXIPTed -- and I wanted to express your smarts and passion but also the priority that you give to people and relationships. So I could spend a lot more time but I'm not going to because we want to hear from you. Dr. Mandy Cohen is an internal medicine physician which is near and dear to my heart and she brings to this job critical leadership, skills and experience in the federal government, at the SAT public health level and a private sector and also brings critically important lived experience including being a mother of two who I think are daughters and now the great ages of nine and 11 if I'm right. So welcome and the floor is years.

>> Thank you. That was very kind. And thank you for the opportunity to speak today but also to get to know you and I want to thank right off the bat the advisory committee. I think you've been doing incredibly important work and I hope you're hearing over the course of the day how it's shaped the work we're doing on lab, on data, on equity and I want to talk about more work that we can do together but let me start with a few thank yous. I have to thank Dr. Houry sitting here with me.

She's been my teacher since I've come here. She's helped me navigate and learn quickly and I know she works closely with you so I hope you know that when you're chatting with her, almost

immediately we have a conversation about it because my schedule looks challenging. And I really appreciate the leadership and ongoing partnership as we do this work.

I also wanted to welcome Adam as the new deputy. It is a new position for the CDC and I think it is emblemate of some work we're doing to Julie's point on how do we think about leveraging work going on across and invest in some core functions that can make us more efficient but our first deputy for policy that is going to make the agency stronger and we were so lucky to bring Andy back to her home where she belongs at CDC. Silly fda doesn't need her so we're so grateful and we have a ton of other leaders around, from Charlene and John is here, Howard and the global staff, my chief of staff Kate and of course, to thank sherri, we're having a celebration for her tomorrow and 28 years of service. The CDC would not be where it is without sherri's leadership and tenacity and I'll get to say a bunch more things tomorrow. So grateful for everyone.

OK. So let me start with a few reflecks from my first I think almost now five months as director. One is to start with my -- with a recognition of the immense amount of work that CDC has going. The breadth and depth of the work is just incredible.

The mission is incredible, of course, that guides us in terms of protecting the health of this country and really the world.

But that -- what that entails in terms of the breadth and depth is immense and I would say I see talent all over the agency doing such incredible work, whether it's responding to viral fever or teaming up with our state and local health departments or it's preventing maternal mortality.

It's incredible how much we have to do but also the expertise that I see across the agency that is incredible.

Second is we have incredible teammates outside the CDC that I've been -- my calendar is so punishing. I've been to many, many, many states already and localities, most of them focused on talking about getting ready and now being in our winter respiratory virus season, talking about the importance of vaccines. I've been to California, to Massachusetts and everyone in between. I'm off to Texas in a couple of days so I'm trying to make sure I'm meeting with folks and hearing them to your point, David, about I do value relationships and showing up in person really helps you know and see folks differently. There's just so many great things happening on the ground around the country and then I also took my first international trip just two weeks ago to Brazil. Howard and I were there together and I saw the importance of our global work really shine through in those moments and the power of those international relationships. We did everything from tour vaccine manufacturing facilities to talk about Brazil's $2 billion they're going to make in the lab capacity which we can both help them with, lessons learned, and thank you lab sub committee but also what can we learn from them as they make the investments so it was a great opportunity.

Maybe the third reflection is that I'm really proud to see this team come out of historic pandemic, learn some hard and important lessons and really embed it into the work. Moving forward was definitely the right track in the right start for the organization and I definitely think the reorganization is going to make us a stronger and more effective agency but moving forward is really more about more than moving boxes. It was really about thinking about, again, how do we embed those lessons learned and focus on rapid intervention of information, working as one team. Those are things that are still underway and again, back to Julie's point of how do we invest in the core capabilities to make us stronger but I see the team doing that every day so I'm really, really proud.

Look. We're in unprecedented times with more and more health threats both here at the doorstep and on the horizon but we also are in unprecedented times of scientific innovation and breakthrough. It's -- we've never had the kinds of tools we have right now to address these health threats whether it's more vaccines, more diagnostic capability, the A.I.

breakthroughs, I think are going to be incredibly game changing for us.

So yes, a lot of threats but a lot of opportunity and, you know, we're trying to use the response to the fall, winter respiratory virus season to embed some of those key lessons learned and again, I bring them from my time in North Carolina and learning there so I hope you see us already as an agency being more transparent in what we are doing. Both the timeliness and accessibility of communications, we're really trying to change that and even how we are bringing together data so Covid doesn't live somewhere separate than flu but you're actually seeing Covid, influence and rsv together in a harm harmonnized way with rapid changes to the viruses and other ways when we saw the early variant that looked worrisome in August, I think we were able to communicate effectively to say here is what we know, don't know and here is what we can improve upon.

Second I see the team really focusing on operational excellence. What I mean by that is not just saying, hey, here's a recommendation for vaccine but actually making sure to hold ourselves accidentable for getting folks vaccinated and that means breaking down barriers to -- from everything from educational barriers to literal distance barriers to cost barriers to make sure that vaccine can be accessible as possible.

The team stood up the bridge program in record time. I can't tell you what an enormous program that is and how fast they stood that up and how it is operating with success across the country to give folks access to no cost vaccines with pharmacy partners and again, that partnership being so importantly but hugely important and sherri brought up the vaccines for adults program SGSHGS that's been in the budget, something that I talk about with members of Congress.

It's our way to extend what the bridge program is doing but that focus on operational excellence has been really great but we have more work to do there.

Then the last, transparency, operational excellence, the last is about building relationships. It goes back to that, David. So I was really heartened to see that one place where I really saw that partnership at work for our winter season is I think you know we have a new vaccine -- or immunization for young babies on long acting mono clonal. When that came on to the market, we didn't have a billing code for pediatricians to use to actually deliver it to get paid. Our team not only worked with ama and aap and others to get the code and then to cms and to adopt it, they got a code to include counseling as well because we knew this was going to be important to talk folks through what this was so it's that kind of enablement, break that intersection between operational excellence, the scientific recommendations and then that partnership piece I think was really outstanding work.

So as I think about us moving into the future, we've been focused on three areas. One I've been talking a lot about which is making sure we're identifying and responding to health threats, the winter virus season being the very most near term thing we've been focused on but we've also focused on two other areas. One of them is making sure that we are focused on improving mental health and addressing the overdose crisis.

I think this is where I want to again Dr. Houry's amazing work that CDC has been contributing data and expertise and best practices in this space for quite some time and we want to even accelerate that further and we're pleased on that work and third, focusing on supporting young families so thinking about -- and you heard about some of this work from Dr. wong today but I could really use your help as we think about those three areas of focus, both the responding and detecting disease threats so right now, we need more folks getting vaccinated and I mean just say I think we could use all voices to articulate good information, to combat the misinformation that is out there to break through a lot of noise.

It's just a lot going on in the world. So beyond even misinformation, folks are just busy and we know that they are -- there's vaccine fatigue out there so how do we work together to break through that and then as you think about these other two collaborative initiatives, thinking how could we work together on furthering the work that CDC is doing with data, best practices and the collaboration so I look forward to your thoughts there.

Deb and I have been talking about a potential working group for you all to consider and I want to get your feedback on this. We started with -- and I started my very first all staff meeting with this concept which is about building trust. Again, I think it is foundational. And I wondered if there was a work group around building trust that focused on communication and partner engagement that might be something that you all could help us think about in the context potentially of these areas of focus or broader.

I think the health equity work group very much, you know, highlighted for us the importance of partnership with community organizations. I'll say that with a very important partner for me when I was at the state level. What are the ways in which CDC can be a better partner to community organizations as we think about making sure we have equity in all POECHLs. So

between want trust building needed on the communication side with misinformation and vaccine fatigue and the partner engagement piece and really figuring out how we further our equity work with community organizations, that might be one way to think about a further work group to help us think about that work because it is --

it would be a new space -- or newer space to build muscle for the organization. So welcome thoughts on that. So why don't I stop there and welcome conversation.

>> thanks very much. Great start and a lot of food for thought there. And you're about to find out that this is not a shy group. And so the floor is open for both questions on Mandy's presentation but also thoughts on future directions of this acd both may be in the areas she's identified as well as others.

>> Congratulations. Thank you so much for those great remarks.

One of the many things you bring is tremendous experience on the health care side in addition to your tremendous experience on the public health side. With respect to trust, one of the key partners for public health are physicians, medical system, patients may trust their physicians, more generally their clinicians and practitioners and others. In addition on some of the priorities that you mentioned, there are opportunities for collaboration with the health care system. You know, one of particular interest to me is the fact that even now, despite enormous amounts of evidence, there are emergency departments that don't offer treatment for people who are incredibly high risk, you know, despite the fact that it offers an enormous decline in mortality and there are randomized control trials and, you know, recommendations from every organization you could possibly imagine, there's still an enormous amount of stigma and people don't do it.

I just wonder, historically, kind of like in a way fda always said, you know, it doesn't get involved with the practice of medicine, sort of an fda statement, CDC is historically staying on one side of the line for medicine. I just wonder how you're thinking about that leading the agency.

>> Thanks. Thanks for bringing that up and we have very much been talking about protecting health as being a team sport and that we need to bring public health and health delivery system closer together and we have to be on one team.

For me the start of knitting that together starts with our data exchange. It doesn't stop there to your point on like how do we go to the programmatic level. One, I think it's importantly the data work that we are doing to knit folks together. I think it's the partnership across the federal government because even if maybe CDC doesn't own every lever, cms very much does. My seven years of spending time in cms thinking about how we can partner together and I want to thank chaquita and John for their deepen gaugement so we actually are doing a lot of work together to think about how to bring some of the work together. Some of the reason we're not

getting engagement on S.U.D. has to do with thinking about how we use the Medicaid 11 waivers and flexibilities but we can get into that another time.

The question as we're seeing best practices and data emerge, how do we make sure whether it's a Sam set or ems can use their tools as well in coordination and it's why we called out that area of focus on mental health and substance abuse. There's more we can do within public health and as well as a great partner there but I actually 100% agree with you.

You'll see in our winter virus respiratory season work that we had most of our communication effort actually is focused on providers, our data tells us over and over again that they are the most trusted and most important reason why folks didn't get vaccinated is because their doctor didn't bring it up.

They just assumed it wasn't important. We've been trying to cut through. There's more to say but I really feel proud that the team is moving in the right direction but always a lot more to do.

And again, maybe as you talk about work groups, maybe there's something specific here on how do we work to bring health care and public health even closer together.

>> thanks, Josh. Julie?

>> Thank you so much for the update and congratulations in your relatively new role. I have a comment -- well, two comments.

One is I'm so glad that you're a strong advocate and proceed pony EBT of the vaccine for adults program. It's been in consideration for a long time and -- vaccine. Sorry. Vaccines for adults program. I think it's a critical infrastructure piece that would be incredibly helpful for us in peace times as well as the next pandemic. It's great to have your support on that.

What I was going to talk about more is the work group. I love the concept of trust and building on partner engagement.

We were talking about the critical role the community organizations played during the pandemic in terms of building trust in the marginalized communities in the country. CDC did wonderful work with the adult vaccination efforts, funding community organizations to get into more local grassroots levels and also making sure the locals could use their federal resources to actually support the ground. We are a national foundation so we struggle with how do we support communities on the ground and we don't try to do it ourselves. We try to do it with our partners who are closer to the ground and I could see an opportunity for the CDC to use mechanisms like that similarly but I would be a strong advocate and support of this work group focused on building trust and focusing with the emphasis on community partnerships as well.

>> octavio and then you're up.

>> Thank you.

>> we're going to robin and then octavio.

>> Sorry. Thank you so much. So glad to see you out of the gate running strong with three really important initiatives. It's exciting to see the energy you bring and I know the whole agency is excited by your vision. You have spoken a lot about community, about partnerships with the state and local partnerships across the government and partnerships within CDC. Can you give a sense of what you're thinking about partnerships with the PROOIFRT sector? I think that's one thing that fda has done well and how do you see that evolving over time? I think that's an opportunity area where there's unlimited outside with all the new stuff coming on board with A.I. and technologies and I don't know how we have formally done that yet.

>> Well, great to see you, Dr. Shaw. And love that question. We have been talking about that actively as a team. I think that there are incredible opportunities to partner with the private sector in strategic ways around some of the particularly new diagnostics that we're seeing in the global space where folks want to do incredible and creative things and want to then use some of the new emerging A.I. tools to help us think about how do you see threat signals from the noise that is out there. So I think that we are -- we're working on how to make sure we're engaging more deeply. I think that hadn't been as top of mind as it --

that the pandemic showed us how important it was.

Let me highlight a place where I saw it work well and lesson learned from pandemic. It was in the laboratory space in partnering with the commercial labs for mpox. We saw there was some lessons learned certainly on the lab side, thank you again to the lab work group on how to do better. I think you see some lessons already happened with the mpox response so when I talk to colleagues at quest or at lab core, they already saw a difference both in how we are just having ongoing conversations and sharing best practices and information but when we need it to turn on that machine again for mpox, I thought that was a real success of partnering with the private sector lab, commercial lab space and one, I think that we'll get embedded into the work we do going forward. I think we can do that on treatment, on A.I., on data. Certainly we're partnering the private sector a lot on data innovations so you'll see more and more I think for that. I think it's necessary. I did it in North Carolina. I think there are places and times where the government innovates and I'm proud that far and -- of that and in the private sector, we have to reach that goal.

>> Thanks, David. Thanks, Dr. Cohen. I wanted to ask you about this country is at an inflexion point when it comes to structural racism and the systemic level and that includes the CDC and 2021 CDC declared racism a public health threat.

Things have changed so much in the past three years in reference to especially coming from Texas, we just passed the anti-bill and the pushback for making these changes that need to happen and even acknowledging in some cases.

I'm just wondering, CDC made a commitment then, wanting to make investments within its organization and then obviously be the leader especially from a public health perspective. How do you see going forward given the environment and your vision and strategic approach to continue to address structural racism as a public health threat?

>> Great. Thanks for that question. You know, the -- I want to go back to some work I did in North Carolina because I bring some of the lessons learned there where we focused on thinking about how do we give everyone the opportunity for health no matter the zip code they are born or live in. NAFS -- that was a very unifying theme in North Carolina. I bring that lesson learned. When you talk about that work being divisive in a place like Texas, North Carolina was a pretty purple state. I worked for a democratic governor but I had a republican super majority.

When I first joined, what was unifying for us was health.

Folks wanted -- they wanted to be healthy themselves, they wanted their families to be healthy and they wanted their communities to be healthy. We all had different visions of what levers we pulled to get there but we could agree that health was fundamental and frankly, it was necessary for our economic success. We started there. Now, it doesn't mean we fixed all the problems in North Carolina overnight. We didn't.

But we are going to extend Medicare for the couple of days.

It took seven years but we didn't get there all the same day but my point is thinking about what are the unifying places that we can work on together that bring us closer to that vision of health opportunities for anyone no matter what zip code. That's my north star of the work.

And then you get to work on transparency, operational excellence and relationships.

For me when talking about the structural pieces, that's operational excellence. There are barriers that keep us from being the most effective we can at achieving that vision. One of the places that, you know, I know we have talked about as a team and I think this work group can help us is how do we work more with community organizations. One of the reasons why it's hard is because structurally the way we give out money and challenging both for us and for the community organizations we want to work for.

But I think there are ways to get past that, but we have to do the operational work to sort of find our way to, you know, improvements there. But I think that's only one of many examples. I do want to commend CDC. I worked in a lot of parts of government and I think that have all done good work. CDC leads with equity in such a fundamental way. It makes me very proud to be part of the team.

Now, is there work to do?

100%. To your point I think CDC needs to continue to be a leader so it's everything from how we collect our data and report it.

We still collect race and ethnicity in lots of different ways across the CDC and our programs. We can standardize that so we just make things easier for our partners. Small things like that and big things like how do we contract and partner differently within the organizations, I think those are all the ways. You know, equity and all policy is the real approach.

>> Thank you for that. You see the work CDC does. Is it possible to have maybe even 5% built into the contracts addressing structural racism or using the appropriate drivers to help disparities or maybe it's a social determinants. That would be great if it was built into the infrastructure. Just something to think about.

>> Yeah. No. I think these are the kinds of, you know, suggestions we want to bring to the surface and figure out what are the right ways. I don't know if -- I don't know if that's the right one or is there other ways and this is where also the partnership with -- sorry to look back over to Julie, ways to think about what are the ways in which different partners can help with that, right? Because I do think in order to work within the organizations, they are going to have to work through a process of being evaluated and giving data over because that's the currency with which we work and so how do we work with partners to help community based organizations be better at tracking their work and feeding, you know, data into the systems.

We did that in North Carolina so we actually partnered with philanthropy to help some community based organizations to be able to do that work and not only furthered that work but it was community development, right? It's economic development work that we were doing so it was really powerful and so we're looking for those kinds of partnership opportunities where we are different but there's other partners who are helping.

I don't want to prescribe the solution yet but I think that's something that a work group could definitely dive into.

>> We'll go to Monica.

>> Thank you, Dr. Cohen. I don't know if you remember me but I had the pleasure of moderating a panel that you were on and the topic was around misinformation, disinformation. And it was one of our highest, you know, rated webinarswebinars.

What I appreciated then and am deeply appreciating now is your relationships. Those are the building blocks that we in philanthropy describe in terms of trust based philanthropy and accountability to communities. And so I wanted to just thank you for that because I think your perspectives are going to be important, particularly as we think about how to operationalize the fantastic work of the health equity work group with the leadership and counsel of Dr. laberg and her team when I think about the metaphors around a team sport, you have a solid team. We are here on the bench waiting to be sent out on the ice. I'll stop there on the sports metaphors.

But it seems like that we are in an inflexion point, particularly in this work and I'm just really looking forward in the upcoming months to hearing the same types of really robust updates

that we got from laboratory work group in terms of how they're operationalizing changing organizational structure, redesigning practices, really taking an enterprise approach, being reflected in the work of the health equity work group so thank you.

>> I would like to ask the acd members who have not spoken up if you would be willing to speak up if you have something to say.

You don't have to. People are allowed to weigh in again. I wanted to ask you a question.

Maybe it's not a fair question.

Maybe it's for the working group on trust.

There's so many different audiences around there around which it's important to build trust, including trust within our own public health system with community based organizations, within individuals, with leadership. In your time here, can you help us think about how you think about those different audiences and without necessarily prioritizing, where should --

where are you feeling the need is most important to start?

>> That's a tough one. You can't just choose one. The two -- if I were to prioritize the two most important, one is to make sure that we are getting timely common sense solutions for real people, for Americans who are trying to keep themselves and their families healthy. They want to do the right things but they need help sifting through all of the noise but they also need something that's going to work for them and their reality.

How do you bring the best of science and evidence and data but also make it practical? I think that's like an audience I really want to prioritize and I think it means not just different messages and timeliness but we have to use different mechanisms of communicating so if they're on tiktok, we need to think about how can we be where folks are getting their information. If it's not for the "New York Times" or the New England journal, it's not. So one of the ways in which we can think differently about being where folks are getting their information, I think you're seeing that a little bit. We're trying. Follow me on Instagram.

We're trying to use more videos instead of written material, trying more podcasts so different mediums as well. That was number one.

Second are the provider community, whether that's our public health practitioners or doctors and nurses, pharmacists.

Those are team members, team public health. But in order for a team to function well, they have to know what play is being called to continue our analogy here of the team sport. We need to know, you know, when to communicate what and make sure they have the good information so we also have to be both communicating the most simple, timely, accurate to the American public and we have to give them more detailed information to providers. We can do both. We are doing both and we need to continue to do both. And there are ways in which we

can make things more public facing and more provider facing and I think we need to do both but I'm sure -- and then there are the deep practitioners, the scientific community that we absolutely need to be more coordinated with and making sure -- so if I was to say those three and again, I think we can operate on all three of those at the same time.

The deep science and making sure we're getting all the nuances and what the science is teaching us, communicating that to our practitioners and then making it practical for real people. We can do all of those but they take different messages and slightly different techniques and we have to recognize that as much as we respect the science and their skill set, there's a conscience to communicate that I also want to see bring into this conversation.

>> Thanks very much. Josh?

>> That's a great answer to that question. I wanted to build on that question about trust. It's the audience but also trust in who? And the obvious answer is CDC, we want CDC to be trusted but I might suggest thinking about that a little broader might also be useful. It's really trust in public health as like a pretty close inside the circumstance TLEL and CDC could play a very helpful role sharing information about strategies and supporting local, state, tribal, territorial health departments as they're communicating. The more trust there is there, the more trust for CDC and vice versa.

A specific example just to make it more concrete is one of the complaints and you were there in the pandemic so you can see whether you share this but a lot of state and local officials were frustrated they were learning about major activity at the fda after it was happening.

People had questions like what does it mean to me? Local health practitioners were not prepared.

It is a team sport and these guys need to be trusted. Then working with Oklahoma state health departments, asking they need to be trusted and CDC being their voice and their needs, it's mutually reinforcing within public health.

>> I didn't hear a question in there but I will say I think great point, particularly when we are, if you will, in peace time, right? We're outside an emergency. How do we make sure that we are creating space to make sure we're getting feedback and that we're not surprising anyone and that's one of the reasons that Andy sitting next to you is here, right? I do think we needed to change and mature our processes of getting feedback and hearing from others so I would say still a work in progress but I hope you're seeing that with the guidelines we are doing when we are in peace time, we want to go through that thorough process.

You know, I recognize that, you know, as someone who has led through crisis, sometimes you learn a thing and you have to say it the same day and you're making a change. So that's going to happen.

But when we have time, for example, we have guidance around using for sti treatment as a preventive and folks are getting input right now and does that work? Is this practical? What are populations? What time frame? You know, those kinds of things. So I hope you're seeing us try to invent those lessons learned but I do want to acknowledge that in a crisis, sometimes you have to move fast and we have to think about how we can do our best, again, that's when we have to kick into overdrive to be listening and taking inasmuch as we can because we have to move fast.

>> Good morning. Or I guess good afternoon now. I'm delighted to meet you and congratulations on your position. I'm Daniel. I was excited to hear you talk about equity and POECHLs and I heard many of your team or your colleagues early today talking about an emphasis on equity. I wanted to pivot to the work force, public health work force and you talked about the extension of the public health work force in communities. And I would be curious to hear, what are some of your priorities to make sure we bolster the public work force in terms of nutrition rates and all of these things with burnout and so forth?

>> Work force is a big topic. If I think about the core capabilities that you all were talking about when I first came in, I think there are five core capabilities that we need to have and fund across all of our efforts, lab, data, response, global and work force. So those are the five that I generally have in my reign when I think about what are the ways in which we need to make sure we have that foundation to do the work on respiratory viruses or to do the mental health work or to do the supporting and families work without that infrastructure.

Now look. Work force is challenging, particularly in public work force because it takes time to train people and everybody is feeling work force challenges. Certainly how the delivery system is in terms of nursing and, you know, we're seeing challenges in all sides.

So, you know, I think CDC has recognized for a very long time.

We've always needed to train folks and head the eis program and bringing folks in. I think there are ways in which we've asked Congress for some additional authority to be able to make sure we retain those trainees and convert them more quickly to full time employees who have taken the time to integrate them and to train them up. We want to retain that talent. And we need some more authority to sort of make that happen faster. It's one of our asks we've been working on regarding our reauthorization work. And I think this is beyond CDC, right? How do we work with our public health schools and make sure, one, that we are finding ways to give folks exposure both to working in the field and working in the government and in academia and how do we make sure we're building skill sets where people can be in academia and then potentially be in practice and make that transition easier for folks. I think there are a number of places and I'm hearing Tom freeden's voice in my head right now because he -- you know, he's an incredible advocate for making sure we have a strong work force and that that work force is well trained and has field expertise and I think it's both. We can't just have bodies. I do want to say one program I'm super excited about was built during the pandemic was working with A

more core and building a public health Americorps which I think is really exciting. I think it builds on sort of the tennance of using folks trusted in the community to be able to do the public health work that is needed. I think that's an exciting piece of work that we've been able to extend.

But again, this is where we're in the confines of authority and funding. We would love to do even more there as we go forward. So I'll stop there.

>> octavio?

>> Thank you. I want to ask you a quick question about organizational behavior. So especially now as the CDC and having been on the acd and some other committees here at CDC, recognizing a lot of the work that's done here is moving toward more collaboration, more transparency, right? What is your strategy for addressing the silo effect that continues to affect all of us no matter where you are. Academia, federal government, even the private sector. What is your approach to ensure, you know, these great things do happen but we have to fight that silo effect inertia that continues to plague us.

>> This is my favorite thing to talk about and Deb is laughing because I talk about it all the time. I -- I like -- I know it's really wonky but I get excited about having organizations work together as one team. It's what I was most proud of as I think of the work in North Carolina and what I left behind is an organization that worked together as one unit. That was health and human services.

Bringing early education with public health, in service of health, health opportunities for all know matter what zip code, right? So that is how my brain operates so for me, there's a couple of ways to do that.

One you call out an area of focus. We're all going to focus on respiratory season, we're going to communicate together as a team. Every single one of our leaders across CDC is doing work on the winter virus season no matter where they worked. They didn't have to be in respiratory virus. I'm looking at Karen who is here who works with pregnant moms and they are very much affected what's going on with respiratory viruss so perfect opportunity for Karen to talk to the community she knows best about what was going on. I think those areas of focus are -- you can't light the world on fire all at once. You pick the areas of focus and drive them forward.

I want to go back to data.

Data is super critical to knitting together siloed organizations. How can you share data across what's going on in the hiv, hep-c world and of course those populations are affected so how do we share data across programs? So data for me is also that organizational piece and then it is actual skill building and training.

I'm really excited that our policy and programs team is actually doing training on partnerships, right? And doing the skill building on that but we have an area of focus for folks to

then affectuate that training. I'm excited. All right. Last thing. Last week we did awards for all of our incredible scientific achievement and that team decided to invite Adam grant to the awards. Adam grant, I don't know if anyone has read his books. I'm a fan girl of him. He thinks about organizational behavior and how do you work differently and collaboratively as teams so he gave just a great presentation on how we can think -- again, skill building at every opportunity even at an awards ceremony.

So I think the teams are thinking hard about it and hears from me a lot.

>> I'm glad you're thinking hard about it. Thank you.

>> And Jill?

>> Hi. Jill. I'm a lab scientific. It's a techie person. I love technology.

Congratulations on your job. If VUN -- have fun with it. So I think public health, we're not at an infection point yet but we're getting closer where the whole public health field is going to change from -- and move from the siloed laboratory with hard walls to point of care, non traditional sites, the home. We talk about the winter respiratory season. Pretty soon we've going to have a toaster sized box in our kitchen and we'll put the capsule in and our baby has flu, do I send them to school. What do I need to do? I need a baby-sitter.

One, it has to be cheap.

It's got to be effective, you know. We have to test -- there's a lot of bad talk about rapid tests during the pandemic because they weren't as sensitive as lab tests. But they gave you information. You know?

I'm infectious or I'm not. Now, the next generation of tests, they are going to be as sensitive as lab tests but they've got to be cheap, OK? So in terms of training, you know, our public health workers are going to be mom and dad at home or a nurse or a non traditional site person working at a non traditional site. We have to think about education.

We also have to think about data. Data and this new technology, we're worried about personal privacy and I get that.

You know, if I'm a non documented immigrant, am I going to say I'm Covid positive? And I have to support my family? Maybe not. But is there data that we can get come to consensus on, you know, if we had zip code, agenda, positive and that information went to the health department to say, oh, you know.

Zip code 12203 where I live, there's something going on here because there's a lot of positives. So I just think we have to think about the word public health is not about me.

That's somebody else. We have to think about population health in terms of personal health. I just think we need to change our thinking completely and that's really exciting but it's a challenge.

>> I didn't hear a question in there, either, but really exciting. When I hear you talk, I just -- I'm excited for the future but yes. Is there a lot in there that we need to think through and start to anticipate?

I think some of the foundational work we're doing now puts us on the road to where you're going because, you know, it goes back to David's audience question.

You need to communicate with a large, very different audiences if we're at the point of personal -- personal health that feeds into population health, that's right. And so I think that's really exciting. But there's definitely some muscles to build. That data capture issue, I love that and I wonder if there's -- now brennan joined who -- who joined the team when I joined here as senior adviser to me for data strategy, he's been working on the health delivery data side. He was chief data officer for cms for a number of years and so right to Josh's point about how we need to bring these pieces together and I think data is a way to knit this together. I think a lesson we have to learn is parcimony. I heard three data points. Zip code, gender and positive or negative on the test. How do we get to that really streamlined way so that we can get initial signal to noise, right? I really love that. So thank you for expanding our thinking.

>> Deb and I had a little bet going into this session. I did win. I was thinking -- she was saying it's going to go long and I said, I don't think this is going to go long. I think that people in their first meeting with the director are going to give some grace as far as how long to pursue a question and answer session sort of on the record. We really appreciate you coming. I think we've heard a lot of good input on the suggestions you have for working groups and we'll take that back and work on them and bring them back to you for our next meeting.

In the context of relationship building, also look towards -- forward to the opportunity of more informal settings, creating those relationships with people that are here. I'm going to give you just one last opportunity. Can you just say a few words about if there's anything that you would most value as far as the relationship that you build with the acd and how we can most help? It's not a tough question.

Just an opportunity to tell us.

>> Well, I think you're doing a great job so thank you. I would say, you know, help us -- help run ahead of us, right? I love where we were just having this conversation where Jill just was about paint the future in ten years and what are the things we need to be getting ready now to think about work force or lab work global or what are those things we need to think about now and make sure that we are challenging not just ourselves here at CDC but challenges ourselves to public health to make sure that we are ready and prepared.

But other than that, I think foundationally if we don't get at the trust building, like that future worries me, right?

And so I think there's the foundational trust that if you don't have, no matter how good your work force is, you won't be successful. So that feels foundational and then help us really look out into the future and what are the ways we need to be anticipating now and so --

because the agency is going through a lot of change now which is exciting and wonderful but like let's make sure we're going through the right change.

Not just where the puck is but where it's going.

>> There's that sporting metaphor.

>> I can't help it. We're out on the ice together. Those would be my parting asks. What a great conversation, opening my mind to a bunch of things so thank you.

Appreciate it.

>> Thank you very much, Dr. Cohen. We look forward to working with you and helping you in your very tough but important job. And we're adjourned for lunch. We'll meet again at 1:30 before starting the second session. About 50 minutes.

Thanks.

>> Let's go ahead and get started. I'm sitting around a table, I can see we have a quorum so we can go ahead and move forward. As a quick house keeping note, just want to make sure that people know we've added the may 2023 meeting minutes and work group meeting minutes to the official acd website and record. And this afternoon we're going to talk about first health equity and then data and surveillance SXIN there are at least some people that need to leave a little bit early so we'll try to move quickly but if we can't move quickly, we'll do it with the people we have left. Moving to health equity as we've done this morning, I would like to have an update from CDC on their responses to the health equity work group recommendations and I'm DLATed to have the presentation. You're on.

>> thanks, and good afternoon, everyone. First of all, I would like to thank the health equity work group for their leadership and contributions over this past year in laying out action items that can accelerate the efforts to achieve equity across this board portfolio of science and programs.

The health equity work group brought together diverse standpoints and lived experiences to strengthen and challenge our ways of knowing and how we engage with the public and proceedng and protecting the nation's health.

We will work hard to move forward the wisdom of the work groupgroup. The action items were adopted as recommendations by the acd and subsequently acknowledged by the secretary of the department of health and human services. The office has been tasked with leading the implementation. Building upon core, CDC's health equity science and intervention strategy, the recommendation center communities and population groups disproportionately impacted by public health threats.

Recommendations focus on drivers of largely preventible health disparities and inequities and systems changes that ultimately transform how we do our work for more equitable protection of the health safety and security of the U.S.

I will briefly review core and then share the recommendations.

I will describe some of what we're currently doing to incorporate these recommendations into CDC science programs and policies and the work that remains.

So launched in 2021, core is the first agencywide health equity strategy and the mobilization of the national centers institute and offices that make up the CDC around this strategy has been impressive.

Core strives to move beyond naming differences through markers such as race to identifying and addressing changeable drivers such as those contextual factors that impact population health outcomes. CDC core framework leaves health equity in the FAB rubbing of all we do. CDC's core commitment to health equity stands on four key pillars.

The c is for cultivate, comprehensive health equity science and in this context we have principles in the design, implementation and evaluation of our research data surveillance and intervention strategies. The o is to optimize interventions and with that, we use scientific innovative and data driven innovation strategies that address environmental, place based occupational policy and systemic factors that impact health outcomes as well as address drivers of health disparities. The r is to reinforce and expand robust partnerships and the e is to enhance capacity and workplace diversity, inclusion and engagement. And toward that end, we are building our internal capacity to cultivate a multi disciplinary work force and more incluesive climates, policies and practices for broader public health impact. The national centers institute and offices submit progress updates to a dashboard and agency-wide reports are compiled by the core leadership team annually. Next slide, please.

So the acd recommendations provide a blueprint that can inform how we do our work, illuminate gaps in the pursuit of health equity and challenge us to a greater innovation.

Consistent with task area one, CDC recognizes community engagement is the cornerstone of good public health practice.

There are many CDC programs that have meaningful community leadership and engagement in their implementation such as the reach program, the partnering for vaccine equity program and community based approaches to reducing sexually transmitted diseases to name a few.

To go back to the reach program, since 1999, CDC has supported the reach program which is an acronym for racially and ethnic approaches to community health. This program focuses on physical activity and other chronic disease prevention activities. In 2024, this will mark the 25th anniversary of reach and it is the longest running racial ethnic disparity's initiative at CDC.

Reaches continue to be a strong, community focused program in over 40 areas across the country. Much of the success has been due to its commitment to community leadership, coalition building and the engagement of a trusted network of community leaders. The office of health equity recently released health equity intervention and action principles which are a set of seven evidence and practice based principles designed to support the development, scaling and implementation of interventions while also fostering systems and processes that promote health equity. To ensure racial and ethnic communities are prepared for the 23-24 respiratory virus season we heard a lot about earlier today, the office of health equity has reached out to community based organizations and national minority serving organizations to put respiratory virus season in the hands of community leaders.

We are also collaborating with the public health infrastructure center and state and local centers to improve and increase community engagement among state, tribal, local and territorial departments of public health. Next slide.

Task area two calls out the impact of CDC's organizational structure on the ability of staff and partners to pursue health inequities. There are numerous statutes, regulations and other federal directives that guide and inform CDC's operational policies, resource allocations and program practices. Not withstanding through core, we convene health equity cme's from across programs to identify health equity guidance that could be incorporated into CDC's non research notice of funding opportunity or what we refer to as the NOFO template. These changes to the NOFO template will cue NOFO writers to address health equity in the design of the NOFO and after published for competition will cue applicants to address health equity in the framing of their programmatic response.

The office of health equity is providing training to NOFO writers to build comfort, capacity and consistency with the effectively integrating the health equity considerations.

Where there are opportunities for wider distribution of announcements, of noticing of funding opportunities, we can work with the office of financial resources to identify those venues that will reach more eligible applicants. Next slide. Task area three, CDC should immediately initiate

a coordinated, agency-wide approach to develop and integrate strategies to influence the effects of drivers of health equity across the entire range of its public health programming.

The office of health equity has worked closely with the office of science to develop health equity science principles. Among domains of excellence for science, the office of health equity ensured the inclusion of a health equity domain that provides criteria for appropriately addressing health equity in the development of scientific manuscripts and other related products. We are still socializing these principles in the health equity domain across CDC. The office of public health data surveillance and technology through the data modernization initiative is working on data platforms to put health equity drivers at the finger tips of CDC scientists which will be followed by the development of tools to assist CDC scientists and evaluators, communities and public health programs in optimizing their use. Much of this work is still in progress. But the necessity of understanding and addressing drivers of health disparities and health inequities using data and other public health strategies, it's a priority for CDC.

So as a result of the health equity recommendations from the acd, CDC has a blueprint from which to chart additional efforts that will accelerate movement towards achieving health equity. We recognize how equity must be at the core of developing any intervention, innovative solution and I will add, including artificial intelligence, policy or programming for populations affected by health disparities, including the authentic representation and inclusion of community members and community based organizations. So as we look ahead, CDC is committed to transforming its public health research, surveillance and implementation science through innovation and collaboration.

Core allows us to learn more about the drivers of disparities and the impact of social determinants on health outcomes.

It allows us to expand the body of evidence of what interventions will reduce the inequities that affect health and invite partners from multiple sectors who can collaborate to implement solutions.

The recommendations reiterate that we must be intentional about pursuing and securing community engagement.

In addition, we must integrate health equity considerations in funding to address drivers of health inequities and we must recruit and retain a work force that represents diversity in academic disciplines, LIed experience and is prepared to do the work that will reduce and ultimately eliminate health disparities while ensuring that all people have the opportunity to obtain their best health possible. With that, thank you.

>> Thank you. Great. Good report back and we'll just open up if there are any questions or comments from acd. I would ask, what's keeping you up at night?

This is a great report and you're moving forward but I'm certain there are challenges so if you would just talk to us a little bit about that because that figures out how we can best provide advice to you.

>> Yep. I was just asked that question -- I don't know --

maybe a week ago. People ask me that question. The director would say in all candor, the thing that keeps me up at night is -- I'm going to call it the lack of understanding of the societal benefits of pursuing and achieving health equity which is resulted in counter narratives that seek to slow --

and I would argue halt -- the progress and the movement of this work. And so what keeps me up at night is how we not lose momentum, how we continue to pursue this work, everything that I have described requires a level of sustainability and so that would be -- that would be the biggie for me. Yeah.

>> All right.

>> Along those lines, what is one thing you want each of us and everyone watching this to do to help advance what your work is? Is it getting the word out about structural racism? Is it taking inaction at work with hr?

What is it that would be the most helpful for you in advancing your agenda?

>> So I would say not backing down from our investments and commitment to health equity. You know, I don't know how forceful the force is, if you will, would be to continue to push against this work but I think just whatever the commitments are in your respective organizations to just be part of really working to keep echoing and to use your voice in support of that. And I think the breadth of health equity is wide enough that you could put a stake in the ground on any of those things, whether it be structural racism or the elimination of disparities in the delivery of health care or in, you know, the failure to adequately engage communities in the work of public health or the failure to use culturally responsive approaches to the work.

So I mean, I could go on.

I think all of those are important. I think not -- again, not being sensitive to how we are unintentionally perpetuating inequities, I would like to really confront those, be thoughtful about how to counter that and then, you know, to do that. So that's what I would say. Yeah.

>> Thanks for your comments. And I think you touched on this in your last response but I was thinking about what it looks like to operationalize the first one, agency-wide leadership in health equity. Are you thinking about -- you know, I think there's a couple of approaches, right? There's like how can we create a deeper bench of folks who understand the issues and also -- or also what does it look like to ensure that every single person, every single leader already here is

well versed and understands health equity and I was just curious to hear thoughts in how you're thinking about that and what that is -- will look like looking ahead.

>> Yeah. Absolutely. So a few things. One is through the CDC moving forward effort, there are three -- with you call them priority actions that come into our office. One of them is the articulation which I have the draft. It's going to be -- share it with our executive sponsors, articulation of a health equity strategic framework that really elaborates core, right? So core is like our coming out the gate, if you will. And so, you know, then training our staff around that strategic framework, that's one thing. We also have, over the last two years, more people in the agency who have been hired with a title of either health equity lead, senior adviser for health equity, social directory, people who have the specific responsibility and they tend to be fairly senior. I mean, some are at the center level, some at the division level but we will be working more closely with them.

Right now we're meeting with them twice a year and we did a survey to ask how could the office of health equity be more helpful and so we will be working at that level with that staff and trying to support them and what they're pushing forward within their respective cio's as well as, you know, sharing with them strategy standards, what have you.

I think we've had a lot of internal activities. For example, we had a diversity and inclusion executive steering committee. We recently renamed it but it's an organization of center level leaders and everyone on the committee has to be at least 15 level or higher.

And so that becomes a forum for us to get these messages out.

Then the last thing I'll mention is we're doing now an annual core forum, the next one will be in April of next year and that brings together, you know, the entire agency.

>> thanks. Last question, ooctavio

>> Thank you, David. Thank you for that update. I had a granular from a budget and resources stand appointment, do you feel that the office of health equity that you're heading up has the adequate resources to implement the strategy you laid out?

>> So our primary resources are our human resources and subject matter experts within the office and so we are certainly optimizing those resources within the office. I think another opportunity is this year through the executive governance board, all of the national centers institute and offices were asked to speak to how they were allocating resources around the priorities of the agency and health equity being one. Those resources are not in our office, those resources are in the cio's but they have made commitments to use a particular amount of money to address health equity within their programs. So, you know, we still have time ahead of us to see how all of that ultimately shakes out.

>> Thanks very much. And our goal is to ultimately make sure you get a good night's sleep and aren't staying awake at night.

>> Thank you. Appreciate that.

>> With that I would like to turn this over to Daniel and Monica for discussion of the health equity work group.

>> WUCHL. Thank you so much, David. And good afternoon, everyone. Really happy to have gotten that update from you.

Very thoughtful update and of course, the exciting work that you've been leading at the office of health equity and with us as a work group. I just want to quickly recognize co-chair Monica and our chair, David, who has been instrumental in the work we've been doing as a health equity work group.

As a reminder, the purpose of the health equity work group was to provide input to the acd on the scope and implementation of CDC's core strategy which you just heard about, influencing internal work and that of the stlt public health agencies, constituents and partners.

Secondly, another purpose is to prepare reports with findings, observations and outcomes to enhance the core strategy.

Third, suggest innovative and promising health equity practices and then fourth, suggest ways to embed anti-racist policies and practices in programs. The work group divided into three task areas to support its work. You heard about task area one which I led. Task area two which Monica led and task area three which David ran.

We want to ensure the meaningful involvement of communities in the CDC digs making in the development of the health equity policies, program implementation and evaluation.

Task area two, they were focused on aligning and restructuring as necessary the CDC policies, resource allocations and program practices to maximize the ability for staff and partners to address health inequities in the day-to-day work and then in the third area, in concert with communities and I think you'll see that as a central theme throughout, all three task areas but in concert with communities, take immediate and decisive action to expand and integrate approaches to measure and influence drivers of health equity across all public health programs. Looking at the upstream determinants of health.

So in terms of accomplishments, overall the work group established eight recommendations to support CDC in advancing health equity. Task area three developed two recommendations that were adopted in February of this year in 2023. A few months later in May of 2023, both task area one and two developed six additional recommendations that were adopted by the acd. And the full set of recommendations were acknowledged by HHS afterwards.

So very happy about that and thank you, the entire acd, for supporting those. I'll turn it over to Monica to discuss the next steps.

>> Thanks, Daniel. Thank you for sharing the updates with us. So as Daniel said, and as landers pointed out, having actionable stepses have resulted in eight CDC recommendations. We feel pretty good about where we've landed in terms of being able to provide insightful ways to really take the commitment and the words and put them into action. In your presentation, I appreciated that you've shared some updates in some of the groundwork that's been laid to advance the recommendations across the agency. As I was listening to you describe the look ahead, first agency wide leadership and also commitment is going to be really important and I think we have shared this in our work group meetings and also at acd meetings how grateful we are that you have been the steady hand in leading the equity of work over many years and it is everyone's work throughout the agency so we appreciate the emphasis on agency-wide leadership and I'll add ongoing commitment.

The second is just also to echo back what you said, this emphasis on engaging and investing in communities and I'll editorialize this a bit.

Particularly those black and brown communities that bear the disproportionate burden of health inequities so I appreciate the earlier conversations with Dr. Cohen and her colleagues or teammates about health equity and policies, health equity across the three focus areas and the way that you are all approaching the work ahead. And then third, strategic foresight and innovation. We look forward to being able to continue to support you all and also to learn more about what you're hearing in terms of innovations and best practices and approaches to really operationalizing the work that has started and in recognizing that racism is a public health crisis and it will take an all of agency-wide approach to address it with all of your teams.

We look forward to receiving ongoing updates in the ways that we heard earlier today with the work group recommendations. We're really excited to hear. Daniel had asked them a question how equity was invented in the work and he shared that there was a position in their work chart for a senior health equity coordinator so that's great to hear that from the top down and we're beginning to see some of this progress.

So we want to give a big thank you and just appreciation for all of our hew members. I will not read all the names on this but we want to just express attitude for the acd members who participated actively throughout the conversations. I want to also thank our public members who were -- who we were able to host in person here for one work group meeting and there was so much work that they did in between our zoom calls and meetings to help us develop the recommendations across the three task areas.

Also want to say thank you to our CDC team and we apologize there were some names we had left out so I'll try my best to remember the ones that I left out that was not intentional so blame me. Dr. August, Kerry caudwell, Bridget Richardd, leandris, Tiffany brown and John arbach who was our dfo so many thanks for all the work to make sure that Daniel, David and I were prepared for the meetings and just helping to facilitate the work and the introductions to

all of your other CDC partners, honestly, who helped bring more life and content to the recommendations that we brought forward.

So I think at this point forward, recognizing that the work group has met its charge, it's now time to consider sunsetting the work group and allowing CDC and the teams to determine and operationalize all the steps you've already begun so I'll hand off to David for the next set of updates.

>> If we could move to the next slide, one more. So we are at this point, because the terms of reference have been completed, considering a motion to sunset the health equity work group. I would ask Monica or Daniel to make that motion. Daniel makes it. Is there a second? We've had a lot of discussion about this.

Is there any more discussion?

>> Yes, please. I would object to the vote to sunset. I just want to make sure that we're able to get an update from the CDC on progress at a later meeting from the full committee.

>> Thank you very much. That's an important comment and we will look forward to continued updates from CDC on this, Rhonda. Thanks. And I didn't see your hand up. I apologize. Thank you for making that comment. So let's take a vote. All those in favor of the motion of sunsetting the committee, please signify by saying aye. Opposed or abstentions? If not, the motion passes and although Monica and Daniel already said this, I think on behalf of the committee, we really want to express thanks to the working group. Daniel and Monica were especially accommodating to my involvement and tolerated it so I got to participate in a number of committee meetings and so both the work group and the CDC support in action and it was outstanding.

And I can't let this moment pass, either, because as with our laboratory work group, we were blessed by amazing leadership in our co-chairs.

Monica and Daniel. And so across our true work groups, we've had dual dynamic duos which I had to practice on the airplane yesterday to make that come out.

Your spectacular leadership has been critical in this. And you're not done. The tor's are finished doesn't mean that anyone at CDC or the acd or the working group thinks that the work is finished. Health equity is one of the most critical and difficult challenges facing public health in our country today and we have a great set of initial recommendations but we need to remain vigilant. We count on you two as well as the rest of us sitting in this room to help assure that you hear from us, we talked about the reports on CDC about implementation and that we hear about, identify and work to solve the range of health equity issues that are going to continue to emerge and will need to be acted on by this committee and across CDC. So Monica and Daniel, the health equity work group and all the staff at CDC who supported this effort, thank you very much.

OK. We were scheduled to have a break but I know people want to leave. Are there people for dsw here or not?

>> could I ask a quick question?

In reference to how important the health equity office is and to go off the comment, is it possible for it to make a motion for it to be a standing agenda item?

>> Sure. Yes. Are you making such a motion?

>> I'm making a motion. I am making a motion that having the updates from the office of health equity to be a standing agenda item for the acd committee.

>> Second.

>> Any further discussion? I love these spontaneous votes.

Thanks. All those in favor, please signify by saying aye.

Opposed or abstentions? Motion carries. Fantastic addition.

Thank you very much.

I'm assuming since we had lunch we're OK moving forward without a break if we can and Deb is going to have to leave at 3:00 so just to make sure that she gets to say what she needs to say, I asked her to stay.

You're on.

>> Thank you. My apologies. I was trying to make the whole meeting but I have a meeting with Mandy at three so got to be there for that. But really appreciate everybody's time throughout the year. I know that this is just when you're here in person but I know between these meetings, there's so much work done with the work groups and tremendous progress and do know we hear you. Today you're hearing updates from our staff, progress. It was a suggestion about bringing sherri to talk about the budget as well. So when you have these suggestions and ideas, know that we hear you and I'm doing my best to always be responsive and bring them. I will do different venue for dinner next time but it was nice to have the opportunity, I think, just to have an informal time to engage with all of you, really appreciate getting to know each of you individually as well as a collective and I think you all have my contact info but feel free to reach out any time and just know that I really appreciate working with each of you and the tremendous progress that the group has really led and David and I will put our heads together and think through what this new work group will look like and look forward to bringing that back to you for input as well. And huge thanks to David for always being our steadfast leader.

>> Thanks, Deb. And that thanks goes both ways. I do want to take this opportunity to express the committee and my sincere thanks to you for taking on this with all your other duties as

assigned and really providing huge leadership to the committee and within CDC, sort of the acd forward so thank you very much.

How about a three minute stretch break?

>> We're working for hopefully before 3:00 stop so that we can get rob on his way to where he's going and thanks, Jen, for showing up a little early. I'm going to turn it over to Jen and the dsw co-chairs for the next session.

>> All right. Can you hear me OK? Thank you. It's great to be here. And thanks for this opportunity to acd on the progress that's been made and I want to acknowledge the great co-chair and leadership. They've been phenomenal to work with and agnes who is there, this would not be possible without her leadership and helping us to keep the surveillance group going. During the course of the work and the dsw, several recommendations have been made and we want to provide an update of the progress. Significant progress has been made to address the recommendations that came out of both sets of recommendations so next slide.

Just to recap, the first set of recommendations that came out of the acd were around generally topics around data policy and data standards, specifically one that the agency should develop a proactive extreme lined approach for the state and local tribe alter tore -- alternative territorial projects and move towards public health system standards and ultimately certification. So I wanted to provide progress that's been made in all three of these areas.

Just as it is, when we're talking about the core data, these are the core data sources defined or referenced in the initial acd set of recommendations. Certainly I want to acknowledge they are not the scope or totality of the data sources we use but the ones that are leveraged quite often and quite significantly in times of responses and for day-to-day public health activities. Next slide.

So the first recommendation was around the use of dua's and the rationale was really to acknowledge the burden, the inefficiencies and the need to have a more streamlined approach to addressing dua's especially with the territorial partners. If we see some challenges that were faced in Covid, mpox and other responses, there's technology challenges around data exchange, the data policy, data exchange have also led to ways in data --

timely data exchange. So the recommendation was to develop a proactive approach for dua's to prepare for future responses.

To do so in a mindset that we have consistency on some of the core common principles as well as the way that we engage with our state and local partners. So a lot of great work in this space. I'm acknowledging Tara who is behind me here and her team that have really kick started and accelerated this important work. There is a three prong approach and the goal is to create a consistent agency-wide approach for the core data sources where there would be a set of common core elements or terms and then an opportunity for disease or data source to be

address where'd there may be variation due to state or territorial laws or requirements. The goal is to make this more efficient as well as transparent in the sharing --

in the relationships we have with our state partners.

As I mentioned, the new dua approach, there's been significant rules to draft this and there's been terms that apply to the core data sources so these are related to established federal laws as well as really important procedures that tend to be pain points such as how we're going to release data, how we would notify jurisdictions and things like that so common, non variable terms and also an addenda to the common terms that can be used for specific data sources. We would also acknowledge that we would have a place in that to address jurisdictional specific terms. We would establish to operationalize this approach, a shared policy governance within the policy and standards position within the data office for CDC. This will allow for accountability as well as streamline engagement with the agency and the state and local partners. Next slide.

So there's been tremendous progress to draft this. They've been working internally with each program that is responsible for these core data sources as well as with our ogc and other partners across the agency.

We've started to socialize this now with partners. Yesterday we were on a call with cste and doing that with all partners and directly with jurisdictions.

Goal is by December, so next month, to transition all the dua's for core data to the data office for management and execution. We do recognize in the next couple of months, especially as we are socializing this with our state and local and tribal and territorial partners there will be feedback and we will ensure we incorporate that into the final dua. And then starting in January, there will be a process to negotiate the terms and to end the agreements with each of the jurisdictional partners.

As we continue to do this, we will want to ensure that we're evaluating for efficiency as well as to ensure it's meeting the needs of data access and data governance across public health. Next slide. What we see as key benefits, one is to really strengthen the data exchange relationships with stlt's. Even mentioned a few minutes ago, technology is a critical aspect but the aspect around POECHLs and governance are critical in knowing the recent responses having this proactive approach with very spelled out and common terms that are consistent across the core data sources will help with that. Increase in trust and transparency with our partners, we do see especially with some technology and efforts underway, there's an opportunity to take the policy agreements and essentially vet them into the technology so allow the technology to help us execute on these agreements.

We also recognize this would provide that necessary flexibility so we would have a common core agreements but the flexibility that is necessary, particularly working with each jurisdiction. Next recommendation was around the concept of minimal data necessary. The importance of

this one was due to some of the challenges again that were apparent during recent responses and for example, when the impact started, the number of variables that were requested on the initial case report forms were hundreds of variables. Is that the most necessary? Is that all necessary? Is it the most essential to get at least early on to ensure we have the robust national situation awareness? So to define what that minimal data necessary is for core public health activities at CDC, recognizing that the state and locals that that may be different as far as what minimal data is but at CDC we should have some consistency that would allow transparency one, proactive preparation not only from the state and local partners but also with health care partners. In doing so, to align these data standards to the fullest extent possible with the health I.T. world. So as they oversee federal partners rolling out ucdei plus that we would leverage for the completeness and timeliness of exchanging the data.

I should have said this for the dea's, too. As these recommendations came out, they became part of our public health strategy goals and milestones.

We wanted to make sure we're counting for that in the data strategy efforts so we have this listed as one of the milestones in the public health data strategy with the particular focus for the minimal data on case and lab data based on where there was the greatest need and greatest gaps, we chose to focus on those two first.

There's been a lot of great progress on case data situational awareness. It should be a straight forward thing to describe the basic core elements we have, there was a need and an importance of getting a lot of input across CDC programs, across efforts underway with our state and local partners, working with cste, factoring in what are those elements? What do we already have? What state and local departments already send?

What's incorporated in the mechanisms or approaches by which they're factoring in the data? So factoring those things in as well as what it is that we really wanted to ensure we can have quick access to and for situational awareness came up with minimal data, line level elements that we would define as minimal data necessary. Next slide.

This effort was started pretty much right after the recommendations came out. We started with the list that --

it's the way that cases send us data for 127 identifial diseases are the core data elements.

There's I think 50, 60 elements in there. We started with that list because that's what they're sending us and working with programs and others cross referenced that with other data elements that may be of importance to define the list and we're now working with our jurisdictional partners to validate that list. Next step would be to then say, how do we line the data elements with help I.T. standards and ensure that the systems that we're all using in public health align how they capture that data as well.

Similar process, just a little bit of a later start has been underway for the laboratory data. We don't anticipate as much challenges in that space or just because it's a little more streamline in the number of elements but that is going well as well.

And now with case and lab well underway, it's looking at hospitalization data and health care capacity. Right now that data is received at CDC through multiple different data systems and we receive quite a few elements and we recognize that it places significant burden on the data centers, whether it's health care centers or state and territorial, tribal partners so defining what we need for the data at times a baseline as well as in times of emergency that effort is underway right now with significant involvement and participation across the agency.

The benefits of this, again, the transparency, ensuring we're upholding the principle of when we're collecting data for the purpose of a public health activity, we're doing under the might not set of what is the minimal data necessary. Two, to proactively prepare our systems in our data center partners, to align with the health I.T.

standards to improve the quality, completeness and timeliness of the data and to have a collaborative approach across the eco system.

And then the last is around the recommendation about public health system certification. This recommendation was to establish standards and also lead toward a system certification. At the same time the acd made a recommendation, there was a complimentary set of recommendations that come out at the onc high tech committee about establishing standards for systems. They are now moving forward with GEing close to the final rule for their first release, hdi1 release and are now moving forward with notice of rule making process for their next set of standards that would apply actually to public health system certification so the onc partners have been collaborative and important part of this approach. What we are looking at internally is to understand the scope of what this applies to and how we would support from a resource standpoint and implementation standpoint a movement towards the standards and ultimately certification of the core public health systems.

So just to summarize, this is something we're working closely with the onc partners because of their legislative authority space as well as experience in system certification, we want to understand and map out across our systems, want -- not just CDC what this would look like as well as how we can incentivize and support movement towards adoption of the certification standards.

So just as a couple of updates to how we envision, one of the things that we were able to fund in this past year is establishment of implementation centers so they are still being stood up and haven't been finalize the but through the public health infrastructure grant program, it allows us to establish implementation centers. It will serve as a regional hub to support jurisdictions in adopting these standards and system requirements so we see this as a main source and mechanism by which we would support state and local, tribal, territorial partners in the pathway towards a more standardized data system.

Internal to the agency, we need to go through the itdg system and make sure there's awareness of what the path would look like and then dig into the governance process what the system standards are so they can review new investments with the right context. And then finally working to identify the different policy and incentive levers that can be leveraged or should be leveraged to promote, incentivize the implementation and adoption of these requirements.

So a lot of great progress in that area. That was the first set of recommendations. The second set of recommendations came out a bit later in May of this past -- of this year in which the focus was on work force so to really help to scope out what the future or what the immediate and the future work force to support the evolving data eco system across public health needs to look like so to assess what the work force needs are across the eco system from a data perspective, develop a XRENSive work force training strategy and then issue guidance on the use of different infrastructure funds that jurisdictions use that can help to support and enable the training of or augmentation of skills with the appropriate work force capabilities.

Before I get to this one just to note on the work force area, as we now suit up the office, we're working to identify where that respond lives but also work closely with the hr counts -- counterparts across the agency, they've had a role in training, work force training as well as the ocio colleagues in identifying the pathway to mapping out what the work force needs are and how we support the training short and long term. Then lastly before I turn it over, there's -- OK, great. Just a bit of background on the new terms of reference.

As we continue down this modernization path, there's been tremendous progress in the exchange of data. I think one of the challenges that we are experiencing and I think is real is identification of constrained resources. There's never going to be enough resources to do everything that we want to do and we have an eco system that is siloed, has a lot of redundancies. We have at CDC hundreds of data systems that are often collecting the same data elements so there's been good strides, I think the initial number was like 600 data systems and now we're down to several hundred data systems but begin, we're pinging partners often for the same data.

As we continue to modernize, we continue to get the ask from whether it's health care partners or other data centers of we want to support the public health use cases. We understand the importance and value of it but we want to know how you're making it more efficient for us, reducing the burden and doing it in a more streamlined and coordinated way.

We recognize that as we continue down this path that it is an important approach and mindset we need to take. We do know it will come with some challenges to really kind of rationalize and streamline the number of systems as well as the way that we pull data and exchange data from the various partners. So with that, let me turn it over.

>> Thanks. I guess I'm just going to acknowledge because he has to leave in ten minutes, I'll chime in and you can pop in as you see fit. I don't want to put pressure on you to get a ride to

the airport. Before we jump into that, maybe what I would like to do is maybe just take a moment and just thank Jen, thank you agnes, all the other members of CDC who really supported the dsw and the dsw members themselves, as well as David. It's clear from Jen's update that a lot has been accomplished, especially related to the first set of recommendations. You've taken those to heart and moved forward and aggressively addressed the issues.

The second set which we were approved in may, we didn't get approval until September.

Because of that, the work has not progressed as much but we're confident you'll make progress on those as well but I wanted to acknowledge the hard work and commitment and what great partnership that we had with all of you so thanks so much for that.

I think that Jen said that now related to the move transitioning from the prior terms of reference to the current terms of reference is that the prior are no longer reflective the priorities and challenges and I think the discussion about the budget today made clear why the budgets and priorities have changed.

This is now the focus of it. If you look at these new -- the new terms of reference will actually address the following challenges and a lot have to do with the resources, limited resources and also inefficiencies within the current system.

I'm just read the bolded parts of each statement and then you all have the slide so you can look through and read them more fully. Fragmented data eco system, data silos and redundancies, inconsistent data quality and health I.T.

standards, resource allocations and sustainability. These are all the challenges that CDC is experiencing right now. The other challenges are the delayed response to public health emergencies because of the fragmented system, integration challenges with the external partners and high burden on those doing the reporting, whether it's health care systems, laboratories or whether it's state and local health departments. That's where I was supposed to acknowledge everybody. So next slide.

So this slide just summarizes the terms of reference from our last round which really, the red are the ones that have been addressed already which Jen just summarized beautifully. The green is the current priority and challenge and the focus of the terms of reference and then the last three are the terms of reference that are no longer reflective of the current challenges and priorities. So we will be -- the plan is for the dsw to move forward focusing on data reporting systems.

So these are the key questions to address. These are the questions to address the key issues in the terms of reference. So again, it really gets into this resource management and also really wanting to make the systems more effective and more efficient overall. So how -- the question is, how can the CDC implement a process to comprehensively assess data reporting systems, aiming to enhance sustainability, alleviate partner burdens and minimize potential redundancies? And then the second question is how can this process effectively streamline the

evaluation of technical, system and procedural aspects within the CDC's data reporting systems while establishing clear criteria for identifying and eliminating redundancies?

You can see this working group is not exiting. We are not sunsetting because CDC, as reflected by Mandy's comments earlier today, this remains a top priority for the organization and also there's a lot of work for this dsw to do so we're not sunsetting. Rather, we've updated the terms of reference to actually allow us to move forward and really meet the needs and support CDC best we can. Did you want to add anything before you head out?

>> I'll just add the editorial comment. I think what you saw from Jen's report out on the prior work, there's a real standard. This committee has certainly taken on hard challenges and you've stepped up to the challenge. I'm really impressed by how hard the work will be going forward, though.

And certainly with Nile and others on the team, we're going to address this first really straight ahead but I want the CDC staff to hear this, too, that this is going to be very hard because there are going to be data sets you've collected for 20, 30 years and we're going to have to say no. Some of the parcimony --

>> As long as it's not mine, that's fine.

>> Deb gets a special exemption for one data point but saying no to a data point that's been collected 20 years and say we're no longer going to collect it because we have to lower the burden. We have to lower the cost. We have to go from 15 giant reporting systems to four.

That's going to be very hard.

And it's up to us to step up as leaders and say, I volunteer to do this on my behalf because I know our data better than anyone else and when are we going to give up and what are we going to get in return as far as a sustainable platform for the future? So thank you, Jen, Nile, agnes and everyone.

>> Is there any discussion or question?

>> I just have one point of information for Jen. And looking at the minimum data set question, iphl and looking at a minimum data set, specifically for getting a test approved by laboratory in an emergency, we're getting to the point, we have consensus between the hphl lab directors and epidemiologists working with Janet. We're now socializing it a little bit broader. CDC is aware of it and I'm blanking on the name of who at CDC knows about it but somebody knows about it. And at a certain point, we'll want to socialize it more broadly with you to work out we're on the same page so it's kind of a -- I see it as a subset of the minimum data set you're looking at because it's specifically to avoid the monkey pox situation where physicians needed to get permission to test. I just want you to be aware of that.

>> that's great. Happy to. Love to see that when you're ready.

>> I think to move this along, we can have more discussion but I would entertain a motion for adoption of the new terms of reference and then we can have additional discussion. Is there such a motion?

>> I move.

>> OK. A second? Any further discussion on this? One small clarification. I don't think it's a clarification but I hope it's part of this is I really appreciated in the terms of reference the notion of alleviating partner burdens and thinking about this, one of the burdens as you all know working at the state and local level is surveillance is the burden of inflexibility financing such that funding streams for specific disease or reporting condition oftentimes are limited to activities around that. I'm not sure that that's s surmountable. I would like to say, can we, in part, alleviate partner burdens by increasing the flexibility that health departments and others have in using fundings so they can use it in the most efficient ways opposed to necessarily continuing to have to abide by the very categorical approaches?

That's probably implicit in this. We'll take the nod of a head as necessity. I will call for a vote on adopting the motion for the new terms of reference. All those in favor, signify by saying aye. Opposed or abstentions? Motion carries.

Great. Congratulations. Thank you very much to Jen and to the dsw for agreeing to take on this additional work.

We're approaching the end of the meeting. My goal is to get us out of here before he has to pack up his stuff. I'm supposed to get some closing remarks. I will just say this has been a great meeting. Thank you all. We really benefitted from these tremendous CDC presentations. It was a pleasure. I think speaking for all of us to get to meet the new CDC director and I'm really gratified that talking with other folks, we all are at the work that has been accomplished across our three working groups.

The differences that we've made in CDC and CDC's responsiveness in reporting back to us how they have and will continue to adopt our recommendations.

I can't go too much further without acknowledging one departure on Bridget Richards as a core support for our acd and she's taken a new job here at CDC. So we're really going to miss you and also appreciate all the work that you've been doing with us. She just is part of the team. Deb spoke to this but really just want to also acknowledge the wonderful support that we all get across CDC, across the working groups from CDC. It really does feel like a partnership and we very much appreciate the work that you're putting into trying to make this work and to make this process successful. Coming attractions?

Next meeting is in February. I forget the dates but we'll work to integrate what we've heard today and maybe getting back with you around some preliminary discussions around working groups, terms of reference, interest in participating so we can hit our February meeting with

our feet to the ground, running, because we need to run to get to where we need to go to. Any other words? If not, thank you very much. We're adjourned.