November 2 ACD Meeting Transcription

needed them of the importance much our global efforts and disease prevention and outbreak response. The good news from domestic preparedness standpoint is that we are just weeks away from announcing an unprecedented, 3.9 billion dollars in grants to our health departments to support work force and infrastructure. These will help develop a work force prepared for emergencies, take steps to upgrade and modernize, to meet new challenges. Many conveyed they're similarly working on activities like our own moving forward, and I do think that's one of the ways we've set examples. We did so in declaring racism a public health threat, did so in the lessons learned and see how we can apply them to be better moving forward. There's still much work to be done in public and policy makers so that they understand the support that we need. There are 80,000 needed. There's a need for sustainable funning. You're going to hear also in this meeting from Kevin Griffith, associate director on communications to what's being done to make sure C.D.C. has clear, accurate, timely, actionable information and I think as mentioned, Dr. Karen hacker, our director of national center for chronic disease prevention is going to focus on social determinants of health. Again, with a critical focus on actionable science and information. I think you're all aware of my passion for health equity. It's well documented and it's been shared throughout the agency. It was among the first things I did when becoming the C.D.C. director and it's particularly important Dr. Hacker is speaking with you on this. I want to emphasize and highlight this is cross cutting. This is not infectious diseases nor non infectious diseases. It's the nexus of whole health. We saw this with Covid. We need to address these issues and where they intersect. So before I turn the meeting back to you, David, let me just thank you for your leadership of the A.C.D. and let me thank all of you for your extraordinary participation in this extraordinary time. Through work groups and our fall meeting. So I know I'm here to take a few questions as well so with that, I'll turn things back to you. Thank you, David. >> Thanks so much. It's great to have you with us virtually and we do want to have you get well as quickly as possible so we're not going to take a whole lot of time for questions but let's open the floor to A.C.D. members who might have questions for Dr. Walensky about the communication or other questions at C. D.C. Lynn?
>> thank you and thank you so much for being with us and I hope that you get better soon. I'm really sorry that you've been going through this with the Covid. It's ironic but I think we're all vulnerable even immunized. But I wanted to mention another communicable disease problem that as a pediatrician, I'm particularly concerned about right now which is, I know you're aware, the elevated incidence of R.S.V. but also concurrently Covid across the country and the two things about that that I find striking, one, is that of course, as a pediatrician I'm familiar with R.S.V. We've always had R.S.V., we have peaks every winter. It's a severe infection. We want a vaccine. At one point I found there was one that wound up coming off the market and we're looking forward to that, right? But so many people are asking me, you know; this a new thing? It's like they've never heard of it before. And I think that, you know, it's been something that we generally have been familiar with in pediatrics but parents

and others haven't been as familiar with it. I just wanted to put that on your radar screen in terms of your communications because people are reacting like it's a new, horrible thing. It is horrible thing but it's not actually unfamiliar in the way that, you know, like Covid was. But the other thing, and this is new, I think, and that is that it's hitting us at a time when we have never been so challenged to staff our emergency rooms and hospitals and I mean, even, you know, in Washington, D.C., it's George Washington university where I am, our director, our chair of emergency medicine was telling me the other day about they don't have the nurses that they need in the emergency department. People are leaving before they're being seen. They're boarding sometimes dozens of people because they don't have enough nursing staffing and I think this is a national issue, kind of falling on the heels of the pandemic, the known thing of people leaving jobs but normally we in public health don't get so involved with these issues but as a pediatrician, this is a major problem if we are unable to hospitalize and to treat and that some of the hospitals are already going to crisis standards of care for children and I don't know what the role is of C.D.C. in that but I do think that this is a major issue. And I mean, I personally would like to see kids -- this is going to be an unpopular point of view but this isn't like it's the common cold. It's OK if people get it. You know? And the precautions that we were taking around Covid, kids who are very vulnerable to severe illness, I think we need to be encouraging people to take precautions because we don't have the capacity to care for them right now. I don't know how we face this honestly. But this is a very real issue. >> Thank you, Lynn. This is something that our team has been working on. We just briefed the secretary on what people are calling TRI-demics, if you will. I just yesterday provided some remarks to the U.S. chamber of commerce on exactly this issue as well. So maybe a couple of points and it's not lost on me that I'm speaking to more pediatricians in the room than I have perhaps expertise on this issue except to say that, you know, my understanding is that in every birth cohort, almost every year, we have about 80% of that birth cohort that gets R.S.V. so for the last two years, they didn't. Now all of a sudden, we have three years' worth of children getting R.S.V. so even if it were not more severe this year, it is certainly earlier and we now have this bolus of children getting R.S.V. Layering on top of that, you know, early indication of at least an early flu season, if not a more severe flu season. Time will tell on that. And Covid. Again, that hasn't been surging but we still have this basal level. We do have promising things in the pipeline for R.S.V. vaccines for adults but also for mono clonal antibodies for children but they'll not be available this year. So a lot of what I'm saying is prevent what you can, get vaccinated for Covid, get vaccinated for flu. Diagnose as soon as you can. If you know that you have Covid, flu or R.S.V., at least two of the three, you could potentially treat if you're elderly and for children, you know, you could treat early for flu. But then importantly, I think to pivot to the work force issue, this is critically important because you can't have your work force out because as we know, as I am personally living, you're out for awhile if you're out and so we really can't have our work force out. We really

do need to do our best to stay well. And so all of those prevention, interventions from a big picture work force, I, too, am very -- I'm worried about the public health work force. I'm worried about the health care work force, the nursing work force. niash has a $20 million grant for centers of excellence to look at work force issues, to look at work force mental health among those issues. But also, you know, I have also said that I do sort of feel like while there are so many people in health care and public health who are feeling burnt out, I also would pivot and say, I actually think this is a bit of our superman moment to say, there's a lot of people entering. Many people have been motivated by the moment to enter in the field. Med school applications are up, public health applications are up. You've probably seen some of these. I would be curious to what I'm saying you could corroborate but to say we do need to -- and it's going to take time to educate that work force. There's no question about that. That is not going to be the fix tomorrow. But we do need to continue that motivation to have people go into this field. >> If I can add, yes, the applications have been up across the country and a really good thing that happened and something that you could reflect back to the secretary, for the first time in more than ten years, there is now H.R.S.A. support for public health students and it is tied to that they are committed to taking jobs in local and state health departments and that's so critically important because if they graduate with a lot of debt, they can't afford to take those jobs. I think this is a wonderful -- and yes, it's a couple of years lag, one or two year process but still, I think it's really going to help. It's also true a lot of people in the public health work force were just going to be retiring anyway because they're baby boomers or even x-ers ready to retire, right? So I think this is the time for that and it's very welcome and we probably need for efforts like that. >> So many of the issues you raised, we're lucky to have members of the leadership team talking with us later today. We'll spare you the questions and ask the tough questions to them. As a last question, I wanted to ask you about an issue you raised we'll not be talking about later today and that's polio. Clearly there's much work still to be done but I think many of us have thought recently of polio as a disease we need to be worried about in Afghanistan and Pakistan and then recently the vaccination for cases in the U.S. I wanted you to speak a little bit to that and some steps that you are thinking that we as a country are going to have to take to pay attention to vaccination here as well as in other parts of the world. >> Yeah. We've been working very closely with -- well, first of all, let me say I've been sitting on the polio oversight board globally since I became C.D.C. director so something we're working on a global scale for as you note for awhile, type polio in Afghanistan and Pakistan but also circulating vaccine direct polio in other countries as well, Nigeria, Yemen, other places that are having challenges right now. So we have a national surveillance system for acute paralysis and this is how that was flagged in this case in New York. We just had an W.W.M.R., I believe, last week. What we've been able to do, we now have over 1200 sites across country that have the capacity for waste water surveillance but we leveraged that in rockland county to see what's happening there but also the surrounding

counties in New York. We have a lot of work that is ongoing in waste water surveillance in that area and you can actually get a sense from the M.M.W.R. of what we've been able to detect in the surrounding counties and how they have been linked not only to the singular pair lit I can case in New York but also how that case links back to cases in the U.K. as well as into Israel. Now, one of the things that we have noted with this case, and just so accuse paralysis, we know with those cases, there's probably many other either sub clinical or mildly clinical cases that don't lead to paralysis that could very well be happening as well. So the answer to that generally is vaccination because there is not much we can do in terms of treatment and we do know that in this area of rockland county, there's particular under vaccination, some of the zip codes in the county I understand are, you know, as low as in the 60% with regard to pediatric vaccination. So that does speak to the work that we have to do in these pockets. This is a similar area that had -- well, the same area that had an outbreak of measles, you may recall in 2018 and it really does speak to the undervaccination and perhaps to the zero dose vaccination in some of these communities. As we're thinking about polio and undervaccination, we did see through an M.M.W.R. several months ago that we probably have a -- well, we've demonstrated a decrease of 1% of our kindergartens in they are comprehensive vaccination. That's 30,000 children entering kindergarten and that's probably also an undercount. We have work specific until polio trying to find those communities that have -- those zip codes and counties that have particularly low vaccination rate. And how they might also have incoming flights of people from areas where polio is potentially endemic. That's work we're doing now encouraging vaccination in those counties. These areas have been refractory to vaccination to date. One of the messages we need to convey is every vaccination is a win in terms of prevention but it's not a quick fix. We have a lot of work to do, a lot of education, a lot of culturally sensitive education to do in these areas. >> Thank you for that. And maybe not surprisingly, when we have an opportunity to chat with you, we would like to take advantage of it so we -- I'm going to have two more questions if you feel up to it. >> Sure. >> From Julie. >> Good morning. I'm not sure where I should be looking. You don't look like you have Covid and I hope you feel as good as you look. And you can weather this next -- this last round as well as you did the last time so good luck to you. >> thank you. >> I don't really have a question. I have more of a comment and an encouragement. I think it's really -- you made a point of highlighting how you are a champion for health equity and that you've made that a priority for you in your time at C.D.C. and I'm hoping that you will continue to beat that drum. What I'm worried about is people are forgetting about the lessons we've learned through Covid and what we saw revealed in terms of structural inequities leading to disproportional impact on communities. I think it's important that leaders like you continue this drum beat related to health equity and you can see it coming through in the different updates we have in terms of moving forward and your other priorities but it just needs to be happening on a continued basis because what I fear is that as time goes on, goes by that we will lose the momentum and the resources that have been flow to go address

health equity and your role is critical. So thank you what you've done and I encourage you to continue. >> if I would just mention that I come to that passion honestly deeply, you know, historically. But what has been really inspiring for me is that actually it's been an incredible moral booster for the agency. People want to do this. And so it feeds forward. It really does. And so I don't intend on letting up but importantly, nobody in the agency intends on letting up and the fact these voices are heard and people can engage and do, I think you'll hear from Karen hacker and others like it's been really inspiring to see what people can do in this space. >> I don't know if you can see but we can see that's right -- hearts and thumbs up. We can see it on the screen. >> I really appreciate that. I think that is exactly the right sentiment. So important. Thanks for raising that. Josh? >> Thanks so much. Good to see you, Dr. Walensky. I think you have more energy with Covid than some of us have with two cups of coffee. You described in your comments and all the work that's going on some pretty scary threats out there, you know, including this ebola strain and all of these different challenges that C.D.C. is working on. There were also some challenges that in a sense aren't real. The misinformation challenges and that really has become an issue with polio. It's become an issue on the issue that Lynn raised, protecting children, Covid vaccination. Some of it is in some ways aided by some faculty from institutions some of us may know well. And, you know, it creates a very different kind of challenge because C.D.C. has typically focused on the pathogen but when you have this level of confusion being, you know, thrown at the public, then it can be hard for C.D.C. to do its job. I know you're thinking about reshaping communications at C. D.C. How do you see -- you know, how is that coming together with respect to what can be done or what C.D.C.'s role is in the bigger challenge of misinformation? >> yeah. Thank you, Josh. So maybe I will just zoom back to the A.C.D. -- or to the A.C.I.P. meeting so folks know and understand. It wasn't obvious to me this was -- I mean, it wasn't obvious to the public what was happening. The meeting that put the Covid vaccine on the vaccine scheduled for children needed to do so so that it would be available in the vaccines for children's program. We need it so everything that is on that schedule is not required. Certainly C.D.C. has no role in vaccine mandates and requirements. We put things on the schedule and then states make the decision as to what they require in their own states and there are certainly many things that are on the schedule, hepatitis a, H.P.V. that are not required for school admission but it can't be leveraged in a vaccine for children's program unless it's on the schedule. That was a necessary step towards access. I want to make sure that the A.C.D. understands that nuance there, that we needed to take that action for access to be possible in vaccines for children. You raise a bigger issue with regard to misinformation and I do think this is among the things we really need to look at in moving forward. We did not have a communications infrastructure that could tackle all of misinformation as part of public health. One of the things I would say in terms of public health education at large is, you know, there are things we learned in this pandemic. Are we -- do we have data analysts that are being well trained in our schools of public health? Do we have communications

that is being well trained in our school of public health? That is going to be part of what we need to train across the country. But within C.D.C. as we revamp our communications discussions, it can't just be how are we going to talk about this salmonella outbreak or how are we going to talk about this polio outbreak? How are we going to take this nugget of misinformation that might be planted tomorrow and prevent it from blossoming? Prevent it from blooming? That's the work we need to do. Probably not just within C.D.C. but really across the whole U.S.G. and we've not yet cracked that nut but I know that is something I will ask you to ask Kevin as well because he's thinking deeply about that, too. >> great. Just seems that, you know, the kinds of communication plans that traditionally have been put together by public health really need a whole new section on misinformation, how this could be misinterpreted, how to, you know, be prepared tore respond quickly. It's a new cost of doing business, unfortunately. >> yeah. >> Thanks. And I definitely agree with Josh's comment about the energy and intelligence that you're coming through with on this. But we are going to let you go because we want to make sure that you get healthy as rapidly as possible. Thank you very much for coming in today and really look forward to working with you and seeing you in person at the next meeting. >> Thank you. Thank you very much for your support and for all of your work and I'm deeply sad that I'm not with you in person. Thanks, everybody. >> Yes? Jill? You're waving. So to try to honor people who might be tuning in for when items are on the agenda, we're a little bit of ahead of schedule because of wanting to make sure we gave Dr. Walensky a break. We're going to break until the top of the hour. We did not have a break this morning so this is an opportunity to get that cup of coffee and we'll see you at the top of the hour. >> We would like to get started if people would take their seats. Good morning. We would like to get started. It's nice to see people assembling rather than in zoom. We're back in place and I look forward to the session we're about to have. Moving forward activity at C.D.C., C.D.C.'s efforts to think about how they can do their work better, including thinking about structure and we're very fortunate this morning to have Mary wakefield and Jim macrae here. Many know Mary as the assistant secretary of H.H.S. during the BAM -- Obama administration and Jim is the associate bureau of the primary health care. I'm going to turn this over to the two of them. I think Mary is going to start off and then the opportunity hopefully for a very robust discussion. Please be thinking about the critical input that this opportunity provides the A.C.D. to form this process. Over to you, Mary. >> Thank you so much. And hopefully everybody can hear me. We really appreciate the opportunity to be here, to have a chance to share with you at a high level of the work that is currently underway within C.D.C. and externally engaging with our partners as well. And very much will appreciate your comments, observations, questions after our brief overview. So please, we're ready for that and we want to hear your recommendations and suggestions even as we're sharing high level what is underway right now. The reason I said high level twice, there are pieces that all impacts the

agency and there are processes, of course, that some of these pieces must move through before we share them in a more public venue. You may have some deeper dive questions that we're not going to be able to be specific about in our responses and just know, it's not because there isn't work underway. There is a lot of work underway related to this initiative. With that next slide, please. It's my understanding that you've been getting some updates on C.D.C. moving forward and its component parts. I'm going to provide an overview of where we've got some of this work underway and then what we really want to do is spend a great deal of time on what the newest initiative in terms of our scope of work that has just been launched within about the last ten days. We want to focus on bringing you up to speed on that. That is this major effort we've got underway that Jim is going to describe for you in a couple of minutes. So for right now, I'm just going to revisit a few pieces of the C.D.C. moving forward initiative broadly and then we're going to go deep into a dive on some specific activity underway. Your questions can be about anything, not just what Jim is going to be sharing with you. So you've probably seen this slide before. If you haven't, these are the four pill our -- pillars of our work. There's a lot of detail behind it in each of these pillars. We'll talk about some of this work as I said, in just a moment through Jim's comments. But bottom line, C.D.C. moving forward, as an initiative, is providing us with an opportunity to meet the expectations, high expectations of our staff, of our partners and of the American public. So all of those external stake holders and internal stake holder as well, the terms of what we do and how we do it are very much in our mind as we are executing on this agenda and the various component parts of C.D.C. moving forward. Throughout this initiative and through the work that's underway across and within each of these pillars, what our aim is, is to strengthen and strategically align C.D.C.'s structure, systems, processes to drive public health action so that firmly as our focus and to enhance within and across the agency features of accountability to enhance and strengthen our communications both internal to the agency and external as well, to enhance collaboration, internal and across the agency, external as well, and to strengthen and improve the timeliness of the agency's work. So broad brush, this is our focus. Clearly we're taking our lessons from Covid 19 and some of the opportunities for performance improvement that emerge there. But frankly, we're not just tying our work to that. We're looking broadly at how this particular operating division can improve its performance along the – in the areas that I just described. Let me give you just a few examples of some of the work that is underway within these pillars and as I said, Jim is really going to talk a lot about that first pillar. He's going to give you the -- our approach to improving how we develop and deliver our science which pivots directly off the report he had done at the director's behest much earlier this year. It isn't that we weren't working on the features since C.D.C. moving forward was announced mid August but that work is very much concentrated starting within the last week. So he'll speak more to that. To give you a few examples of

some of the work underway in some of the other pillars, the communications piece as you can imagine, I just mentioned communications as an area of focus but as you might imagine, communication both within the agency, across H.H.S., with the American public to public health systems, from state health offices across states, territories, Indian country, et cetera, all of those are key communication pathways very uppermost in our mind and there's a tremendous amount of work underway within the communications component of the -- of C. D.C. Many improvements. Jim will probably highlight a couple of them but many opportunities for opportunity in that area led by Kevin Griffith. As the lead of the communications shop for C.D.C., this is a major focus of his work that communications improvement piece and we've got a number of activities, as I said, underway in that space that he is leading and his team is leading. Secondly, we're also, again, thinking about some activities we have underway in these pillars. We're very much investing in the leadership of this agency as well. This is an incredibly complex agency. I know it from having sat in the deputy secretary's office that -- and having looked across H.H.S. in that capacity and the Obama administration that the depth and breadth of this agency's work is highly complex and it's important that our senior leaders have all the tools in their tool box, the strengths, skills, in addition to their content expertise to lead this agency strongly so we have a particular initiative underway that is led and has been operationalized now for a couple of months and it's going to roll through well into next year to help strengthen and support, really provide support for our senior leaders as they lead this agency. Not just through this incredible time of change but also, as I said, just giving the complexity of the agency's work on a day-to-day basis so there's a lot on the shoulders of the senior leaders across this agency and we want them as supported as possible and we have investments and assets that we've directed in that area as well. Again, just giving you some high level examples of some work that's underway that are a little more granular than in the slides right now. A third area that I wanted to mention that we have is real eye towards the core capabilities of the agency so our data science, some work that this group is also involved in and helping us think through and helping the director specifically think through. Data science, lab, equity and so on. Those core capabilities are very much front and center for us as an area of focus and opportunities for improvement within those areas. Just a second I'll give you an example or have an example shared with you in the lab area that that focus also fits these pillars that is a sharp focus on core capables in the agency. Continuing to give you, again, some examples of what some of the activity underway in these pillars to hopefully breathe a little life into what this represents, we also have activity underway that draws on work that's being done in the agency that begins to close some gaps. So in other words, where challenges and problems have been identified within the agency by Congress, by H.H.S., by the staff within C. D.C. We've got those challenges and

problems that may have emerged clearly and as associated with Covid 19 or may have been evident even before Covid 19, we're starting to close some of those gaps and we are now beginning to wrap narrative around some of those solutions that are closing some of those gaps so we can begin to talk about them. In other words, we're not waiting for six months from now or a year from now to say, here are the 15 things that C.D.C. has done to address challenges and problems. We've got those now starting to be packaged for consumption by external audiences. So just beginning that work pulling them in. And we're calling them impacts because obviously this is it. We're looking at the impact of solutions being brought to bear on some of the challenges that have been fairly visible in -- to those broader publics as well as visible within the agency itself. I want to share with you one example. I'll have a colleague share one example of closing a gap, a piece of a gap. I've asked Dr. Purple to share something in the lab space, again, associated with core capabilities. This is just to give you an example in all of these cases, illustrations of some of the work at a fairly high level we have underway. Jim, if you wouldn't mind, this is the kind of thing where it's a solution to a problem that was identified and we'll have many more of these. As they keep coming in, we'll continue to share. >> One of theed things that was difficult in early Covid, we had a problem with laboratory testing at C. D.C. Before a test goes out from C.D. contribution it undergoes a quality assurance review but the review was not adequate and it missed something that was important and it ended up being that the test that was handed out was not as good as it should have been for its intended purpose. That was our fault, something we needed to fix. When we looked at solutions to that, the eventual solution we came up with was to establish something called the infectious disease test review board. That means that any test that is developed in the infectious disease laboratories at C.D.C. undergoes a review by this board before it is shared outside of C. D.C. That review consists of three subject matter experts, independently looking at the method validation and quality assurance around the method and independently validating that the quality is suitable for the intended use. Then they submit their report to the board to compile to make sure everybody agrees and to eventually vote on approving that test. So this gives just a much more extreme and substantial review to quality but we think that that's merited because we never want that to happen again. We're actually able to put that test review board in place as of march 1 and when monkey pox came around, the monkey pox testing went through that before it went outside of C.D.C. as an example of something that would happen. And as we worked with the laboratories, we want everything to be ready and in place before it goes to that test review board and we were very successful with that with monkey pox and the entire review process only took 36 hours. So it would not be a significant delay in terms of responding to a major emergency. >> Thanks, Jim. I've been talking broad examples but I want you to hear an illustration of some very specific

solutions applied to features of challenges that the agency faces. Jim mentioned one piece but there's a lot of other work underway in the lab space as I mentioned earlier. We're focused on core capabilities. That's one of the areas across the agency. He's got a lot of other pieces being crystallized now and that relatively soon we'll be able to be back to you probably even as soon as December with some of those additional pieces and I know some of you have expertise you're bringing to the table in that front as well. Let's shift to one more piece I want to drop into this pillar by way of example of some of the work that we have underway. These will be the next slides, please. If I could have that. OK. Sorry. I thought there was a different slide up or that we had in the set. Let me give you one more example of work that we have underway before we go to this slide. We also have associated with those pillars, and you've heard about this already, the work of reSORGS of the agency to better align the assets of the agency to deliver on the agency's mission. That work through strike teams across a number of about ten different functional areas has been underway now for a few months and that work focuses on -- in terms of the strike team area, it focuses on public health area, global health, external affairs, laboratory safety, science and capacity, public health readiness and response, advancing he canequity, public infrastructure, science, policy and communications. So working on strike teams designed to look in each of the functional areas and think about how the organization can better support those particular areas. So all of those recommendations are sitting right now with the director and she's reviewing them. This is all information that her senior leaders and others have informed. These reviewing them and our plan is to have those recommendations start to move through the formal required process beginning no later than the end of this calendar year. So that reorganization effort also drops into one of those pillars is well underway. As that work is starting to recede from involving the broader part of the agency and it's sitting with the director and then it will go through normal H.H.S. channels, as that work is starting to drop down in visibility, it goes through the normal processes, the other piece of work that we're here to talk about, which is the operationalization of the report that Jim macrae did. That work is ramping up rapidly and that's the piece we want to drill down more specifically for this particular presentation. I hope this gave you a flavor of some areas but I'm hoping you'll take away from this the breadth of activity we're hitting on a lot of different places through the C.D.C. moving forward initiative and we're doing our level best to apply, change management principles through this process, including engaging as much of this agency's staff and obtaining their input as we possibly can because at the end of the day, it's all about designing the process structure functions in a way that supports the incredible expertise that is found within this agency. So in the process, these are not being designed just by one person or out of the office of the director. It is at the director's direction but it is very much through the lens of engaging as much of the C.D.C. as we can. You'll get that from Jim's presentation, too. Thank you. >> Thank you, Mary. I always feel like when I'm on

the east coast, I always want to say good afternoon or good morning to folks on the west coast. It's early but it's great to see you all. It's nice to see some familiar faces and just really appreciate the opportunity with you today about C.D.C. moving forward. C.D.C., I'm having trouble signing in so give us a second. That will give me an opportunity to say, I really appreciated the opportunity from C. Walensky to review the C.D.C. and the operations. What she asked me to focus on was how C.D.C. could better translate data into actionable policy and communications. I will tell you, I took the whole effort incredibly seriously but I want to recognize her and the staff at C.D.C. for undertaking this review. It is not easy, especially in the middle of a crisis to go back and look at how you did and what you could improve upon and I really want to commend her and all the staff for taking what is really, I think, an incredible opportunity to look at how things can be improved and in the course of my review, I found a number of things that really are strengths within the organization that could be built upon. The staff really have done a remarkable job in responding to Covid, responding to monkey pox, polio, all the things that you talked earlier with the director about and really did it with an incredible commitment and dedication to improve the health of the country and really prevent much more significant things from happening here in the United States but also globally. But there also was a recognition that there were some things that the organization could do better. There were a lot of things identified externally to the organization, things that could make it easier for them but my report was on internally how C.D.C. if you thinks and operates. I really take that to heart in terms of what it means to look at yourself and really try to improve. My report itself reflects really the view points and priorities from a little over 120 internal staff and external partners. They gave me a lot of feedback, a lot of feedback, a lot of ideas about what could be done to improve and what I attempted to do in the report was try to identify what were those key priorities that the agency really needed to focus on. And there were five main ones that surfaced. So I just to want run through that very quickly. And more importantly, give you a little more context about why these were the priorities that folks both inside the organization and outside were really focused on. First was around sharing scientific findings and data faster. What people overwhelmingly said is that we value C.D.C.'s expertise and knowledge but we need to know it as soon as they are comfortable sharing it. It's not good enough to wait until everything is perfect to be able to share that information because we as policy makers, we as providers, we as the American public have to make decisions and without that expertise and knowledge, we really can't make those decisions in the best way possible. So really helping support the agency to be more comfortable with sharing what they know when they know it. The second thing, which I heard quite a bit was, really trying to translate science into easy to understand practical policy and guidance. Number one, there was a real desire to do less guidances that covered more circumstances and they alsomented those guidances to be less complex and easier to understand. I also heard, especially from partner organizations,

that they wanted more input in terms of as guidances were developed both in terms of the priorities about what to focus on as well as getting real world feedback how best to implement the science and just make that part of what C.D.C. does. A third piece was around prioritizing public and its underlying health communications. Again, and I heard this quite a bit, is that the American people and the global community actually need a credible source of information and they really do look to the C.D.C. to do that. But C.D.C. has not focused as much as it needs to in terms of really being able to communicate much more clearly through the American public to the international community and it needs to beef up the capacity to do that work. The fourth thing was to develop a work force prepared for future emergencies. This is really recognizing that C.D.C. is both a science and a response organization and that they need dedicated work force that are available in any type of emergency. They cannot depend on detailees. They cannot depend on volunteers to staff an emergency. You need a permanent cadre and then supplement that with volunteers and others to help respond. In addition, I think the pandemic highlighted needs tore different skill sets, whether that's in data analytics, data visualization, communications, policy development, ability to translate science into actionable policy, just a lot of needs for different skill sets that the organization has some capacity but really needs to beef up. Then finally the last piece was around promoting results-based partnerships. It's not enough just to share the latest science or data. It's really important to translate that science and data into action, into public health action and it needs to be done in partnership with implementers. C.D.C. can't just sit back and provide what it needs to share. It needs to be actively engaged with partners in terms of implementing it. And again, there are pockets where that's happening and it absolutely did happen but there's just more of a desire for it to happen on a more routine and actionable basis. And those partnerships, especially with the grants, need to be much more focused on what are the results we're trying to achieve together rather than requirements. And really be like a laser on those requirements themselves. Let me see if I can go to the next slide. So from the report, and I hope you all have read it, if you haven't, I encourage you to do it. It's not very long. It's about 5 1/2 pages. That was done purposely because I really wanted it to be much more of an action oriented document about what things the organization could do and try to give as much concrete examples as possible so that it wasn't a report that just sat on the shelf but actually was something that could be used to improve the organization. We're doing that now at C. D.C. We're translating it into action. What we did is we looked at the report. Even though I personally loved all the different actions that were presented, we did prioritize those to a corset of about 21 different actions we thought were critical for C.D.C. to underway right now to get moving on. And I'm not going to go through all of these but there are 21 up here so you'll see all of them. I want to give highlights on a couple of those just to highlight what the thinking behind it was. So the very first one is around developing and UTD utilizing standard language for clear understanding. That

was done in other countries. It was done internationally in the U.K., Australia and it's something that a lot of C.D.C. staff are interested in doing more of which is sharing what you know but clarifying exactly what level of understanding you have, what your confidence level and being comfortable with that. One of the things that came out was the need to have that standardized language to clarify what that looks like. Another big piece and I'll draw your attention to priority action 2d is to really strengthen the review process itself but also streamline it so it's -- that may seen contradictory but it's having less people involved in the review process but making sure the people involved are the folks that can provide substantive comments so documents can get out more quickly and that's a recommendation to include outside reviewers as part of that review process. Next slide. Next page, the big result here is really to develop a more standardized policy review process to take the best science and absolutely stay consistent with the science and follow the science but to also add in other factors as you're thinking about how people can actually implement and deliver upon that science. So taking into factors issues of feasibility, issues of health equity, what's the impact going to be on different populations, what are the net benefits and just making it very clear as you're developing guidance or policy that you are following the science but also taking into account some of these other critical factors in terms of how to actually implement different policies or implementation guidances. The other piece just related to the guidance itself is just making it much more clear language. Really to focus on the public especially in the very beginning. That's one of the very maniations that's later is make it clear to the American public first, what is the guyedance -- guidance saying and then just make it very clear what needs to be done. Next slide. Two issues defensely related to communications and I'm not going to spend much time because Kevin Griffith will be with you later today. Really having a consistent risk communication strategy. It was brought up earlier with Dr. Walensky about how do you respond in a social media environment? How do you speak with one voice? How do you deal with misinformation, other sources of information? How does C.D.C. engage with that in more effective ways? Another big piece is when things are rolled out and again, heard this a lot from partners, that there's clarity to the public about what the guidance means but then there's also information provided to state and local health officials, to providers so they better understand why is this guidance being put out? What is the purpose? What does it mean for us as a state level, a local level, a provider level? Go to the next slide. So developing a work force, I've already mentioned this about having a permanent staff is critical. The other piece that really came out through all of this work was really the need for C.D.C. to look inward in terms of issues of diversity and inclusion, in terms of recruitment, to really have the organization reflect the pop LAPGSs -- populations served so it can be incorporated in the decision making process itself. And then finally one of the things that really came out here is the need for clear sort of new goals and objectives for the

organization going forward. I would say that's a big part of moving forward is really that internal sort of in-depth look at who you are as an organization and figuring out where your strengths are, where the weaknesses are and then working with others to declare what it is that you think you should be and working towards that. And so having that clear set of goals, priorities and actions so that people know what it is they can expect from you, what you're going to deliver and then how best you're going to deliver it. And that really leads to the last part if we can go to the next slide which is, developing a performance framework to really be able to document clearly what the organization is able to accomplish and thinking about it, not just in terms of results and outcomes which is critically important but also how are they doing in terms of getting information out in a timely and a quality way? What does staff think about the organization? The staff has been through a tremendous amount of upheaval and change and how do you continue to support an organization to deliver the best service that you can? And then finally, the whole idea of getting feedback from your customers or your grantees and doing it in a real time basis. One of the recommendations is the organization conduct annual surveys of its partners to see how they are doing and to get real feedback about what they can improve. The last two priority actions, and I think this is a great example of the 11a is engaging senior leadership and decision makers in ongoing forums to receive feedback and what's important is meaningful feedback and discussion and back and forth to see what needs to be done so to basically have that real kind of conversation and dialogue. And then lastly, that whole idea of really developing a partnership approach in terms of grants. So we can go to the next slide. How are we going to do this? So as Mary mentioned, we've set up 21 what we call priority action teams and what we have basically charged each of these teams to do is to begin to implement the actions that we just went through with you all. We're asking each team to come up with sustainable solutions that drive results and I really want to underline sustainable. What we want is real change within the organization, not just one offs but real change and with that real focus on results and what it is that we want top accomplish through all of C.D.C. moving forward. We have folks that are leading this effort. They're not our traditional folks that lead efforts so we are doing a level down from our center and office directors and we're engaging the staff to lead this effort. It's part of succession planning but it's also part of making sure that other voices and perspectives are brought into the mix. We also are trying to make sure that as part of these teams, we're bringing in people from different organizational units with different skill sets, different grade levels, diversity experiences to really make sure we're all encompassing within our own organization in terms of doing this work. We also want to, of course, engage with external partners as we develop implementation plans around each priority actions and our goal, it's ambitious, to COMBEMENT -- implement the plans by the beginning of December. The whole idea is to begin the process of change and we'll incorporate opportunities for feedback along the way both internally and externally to

make sure we're hitting the right mark. And it's really the whole idea is for C.D.C. to become even more of a learning organization, more of an organization willing to try new things, pilot test it, see if it works and then adapt and change so that it needs to because that's really the muscles that it needs, I would say, going forward. So that's just a little bit about the report, the specifics around delivering on science. I think we go now to the discussion questions if that's right, Mary? I'm going to turn back over to Mary for the discussion questions. You don't want me to leave? I can leave. It's all good. >> I want to add in that I might add to Jim's comments. Jim, you'll want to come right back here. >> Want is not the right word. >> I know John thought this was better for the ex TERJ -- external audience. One thing I was going to add in terms of engaging external partners but also what we're doing is looking at where we can create more porousness and the boundaries between the agency and external partners in our processes and structures of this agency. So we are working closely with our office of general counsel to say, in addition to faca, the world of faca that govern this type of input process, what are our other options that could, where it makes sense, be baked into processes of the agency? I'll just give you a hypothetical and I'm not suggesting this is going to happen but just give you an example of what I'm talking about, let's say when the agency tees up research questions, whether it's in a response mode to a new ebola strain or it's something else and the response mode or just in their day-to-day book of business, maybe other chronic diseases, the -- is there a way that we can invite perspectives' opinions, view points from external partners about what the priority research questions should be? So yes, of course they're informed by our experts within the agency, that's a given. But what else do we need to know as we prioritize, think about and prioritize the research questions that would be the focus of some of this work? Is there anything we can glean in terms of view points from outside audiences? At the end of the day, this is where a lot of research ultimately lands so what could we learn from state health officers, for example, about what they -- answers they need to have in order to execute on a particular health challenge within a state or locality and so on. I'm just tossing that out as an example so we know we have F.A.C.A. options and there are some other options all within a legal parameter so yes, it is to get outside partner engagement in the strike teams that Jim just talked about, but it's also, where do we have the opportunity to create more porous boundaries that make sense and invite input because of the uniqueness of this agency which is really operating in such close partnership with entities across the country. I'll stop there. I just wanted to add to you. Back over to Dr. Fleming if you want to take us back to this next piece. >> Thank you very much. And just speaking from my perspective, great thanks. You've all done a remarkable job, I think, in identifying many of the key issues that are the important ones to tackle so we're very, very excited to have this opportunity to talk with you today and hopefully into the future as well. We have about 20 minutes so I'm going to open this up to the

floor and really I would ENcourage folks to look at the questions we were asked and try to provide feedback on issues that you think are important. In addition to questions that you might have but this is really an opportunity to give advice so starting with Jill. >> My name is Jill Taylor and my passion is laboratories. I come from a public health background. So I want to focus in on Mary just what you talked about, about the porous walls because I think that's important from two perspectives. One, building partnerships and two, reaching populations. Let me focus on the partnerships. I think in the large system, we realize very quickly, and I think the pandemic shows us that one entity can't do everything. So you start with public health, then you get clinical and the commercial and academic and they all play -- have an overlapping initiative but they play a different role. And I really think it's important for C.D.C. to think of itself as part of the system and make those walls very porous. It plays into laboratory and, you know, whose role and responsibility is what at what stage of, say, a pandemic plays into data transfer. You know, there are many commercial entities who know so much more about data transmission than government does. We need to take advantage of that knowledge. It plays into diversity, equity and inclusion and of course it plays into laboratory. So it's just to do what you're doing, make the walls more porous but make them very porous, please and really think about partnerships in a system. Thank you. >> If I could just say thanks so much for that observation and just in the laboratory area which is not an expertise of mine at all, we've had some conversations obviously with Dr. perca who is on the public and private side as well in that space and talked about strategies to leverage in even more so so your putting a marker down on that is a reminder for us to lean in even more. Thank you for raising that and flagging it. Yeah. Really helpful. >> Folks on zoom, if you want to make a comment or ask a question, please just raise your hand. I can see that. Flipping to the other side of the table, Monica. >> Thank you so much for the overview and then drilling down to specific examples and I appreciate the language that you've used which resonate for me having served in local and state health departments around performance improvement and quality improvement because these are the sort of values and principles that the C.D.C. is often co-led with public health accreditation so I'm glad you're applying that internally in this review. I'm just curious as you were describing the ten strike team functional areas, it probably strikes all of us that many of these are cross cutting such as equity policy and communication so I was wondering if you could just describe how -- what the line is and how you approach this work with some of the cross cutting functional areas. >> Sure. Deb, do you want to -- not to put you on the stop but you've been working more on the strike teams than either Mary or I have. >> Sure. Happy to answer and robin is here. The strike teams focused on the structural changes of the organization and then we worked with Mary and Jim really around the priority access teams to look at more of their system or process barriers that we can really use to lift some of this up. For example, the policy strike team is looking

at, what is the best way to coordinate many of the different components and policy across the agency and other structural changes that are needed for that? And with respect to equity, the director, you know, has highlighted the need to have an equity office. We do equity activities across the agency and we want to make sure we keep it embedded across the agency but what is the role of the office to really highlight, augment and spear head many of those activities? Robin, anything to add? >> No. I think you covered it well. The idea is really around having our opportunity to ensure that C.D.C. priorities as it relation to equity is seen throughout the entire enterprise and as each of the centers present THIRP plans for the next fiscal year, that information is considered and we have the expertise in each office to work with the directors office to make sure we have a clear equity strategy to also help inform what Jim was talking about relative to making sure that all the pieces come together and that the focus is where it needs to be relative to the priorities of C. D.C. >> And if I could just share an opinion on that, my own personal opinion, the director is very strong on this issue. I mean, this matters deeply to her and she's communicated that to her senior leaders and across the agency. This focus is really important. And I've really been -- I found it very refresh to go see how this agency is focusing. It's strong, it's threaded through. This is not a one off. OK, that office over there is going to handle this set of issues. This is really strong both in terms of the internal work as well as external engagement and it's impressive. I would go so far as to say I think from my former experience, C.D.C. will be a showcase for the rest of H.H.S. on this if they continue to move in this area based on my prior experience in the office of the secretary. They're really moving hard on this one and I think commendable to robin out of the work of the strike teams to how it's embedded in the priority action areas right all the way down to the nofo's, the grant opportunity announcements and our orientation there. It's pretty impressive. Always be more to do but they're in a very good place, I think. My opinion. Yeah. >> And as a little bit of an advertisement for this afternoon, the health equity work group is coming forward with some proposals for key actions that C.D.C. might consider as part of this. I'm going to reserve the right at the end to do a followup question here but I want to honor who raised their cards already. We'll go to Lynn, Josh, Julie and then octo. >> I want to recommend that we actually do a work group on the science and research issues. When I think about it, during the pandemic, I would go to U.K. counterpart for the C.D.C. for getting in-depth scientific information, not the C. D.C. And that's because I think C.D.C., you know, tries all in one place to communicate, to state and local governments, to the public, to clinicians, everybody but it doesn't really put together the kind of dance technical reports that scientists want to read. And that makes it very difficult as a time when a lot of scientists actually really need to know what's going on because it's all hands on deck when ear dealing with a pandemic. When I noticed you couldn't get to that, there was no underpinning, you know, the actual technical analysis to look at number one. Number two, where

is the external engagement of the scientific community and peer review? Zero. You know. So mmwr, it's an internal per review. I don't know if it's something that is in terms of what C.D.C. ought to do to communicate science to be honest, but it is possible in the federal government with F.A.C.A. rules to have standing scientific advice that is brought to bear quickly and I could go on and on about different ways to do that. I did it at the E.P.A., others have done it. C.D.C., it's all internal. And here's the thing that's complex. If you have anything like a monkey pox, probably the only expert in the country is someone who works for the C.D.C. so it's not that there's a better expert somewhere else but you also need people who have a broader scientific expertise looking at these issues and helping, you know, with reviewing designs and analysis and the actual product and it's just not happening. So it's a complicated issue. >> It is. What I'm hoping the report will do and the feedback, there's a lot of similar feedback and I tried to reflect that back in the report itself. A lot of this is asking C.D.C. to really look at itself differently and how it engages and we were just talking about the cross cutting pieces. It's basically saying across the enterprise we're going to do things standardized in terms of how we're going to collect information, for example, on health equity to make sure we're consistent across what is our role vis-a-vis science? Is it that we all do it ourselves? One of the recommendations in here is maybe C.D.C. can play more of a convener role.Ic it's getting clarity about what you can do well and then as you said earlier, the porous boundaries of how do you actually do it? So be clear about what C.D.C. should be doing but then also make it clear that C.D.C. isn't alone in this and shouldn't be A LEN and should be working in partnership with others. >> Deb is going to deal in on this, too, because there's exactly on the points you just described, that's been a major thrust of our focus to the priority action teams and through other work. Deb, do you want to -- >> Yeah. Thanks. And great comments and feedback. I wanted to highlight that with the center forecasting and analytics, they've been working on technical reports and we've done two for monkey pox. That's one way we're bringing the scientific data and the findings out. I think Jim and Mary have been great in pushing us to think how we can involve external experts more but I did want to highlight also some changes M.M.W.R. has done recently including releasing graphics in advance. There was a monkey pox paper that was released, I think within a week of -- under a week, just days in having the data and part of that was just once we were able to collect data with the paper reduction act waiver, we were able to do that. So we're looking at things to get data out but appreciate it. >> We've seen the new reports on the forecasting and analytic websites. Those are great. >> Wonderful. >> Can I see octavio, you have your hand up. Josh and Julie, I don't remember who I said next. Josh, you're on. >> I think you might have said Julie. That's totally fine. >> She said you so we'll go with you. >> All right. So my question relates a little bit to this -- this is a

medi question. You're doing an important, difficult work at C.D.C., C.D.C. is mobilized around this and it's very difficult to communicate about it because it's kind of abstract, you know? You know, the different strike teams and the different recommendations. I mean, frankly, I probably need a translation to really understand them myself, even knowing C.D.C. reasonably well. But there's a loft attention to this because it's an important effort that C.D.C. is launching for improvement so it is in a way an opportunity for communication generally about what the C.D.C. does and trying to do and I wonder if you thought about how to use this in that kind of way. For example, you might say, look. Here are ten things that C.C. will be able to do BERPT better and we're going to report how these things are better pending that they really matter to people in the country, you know. How do you -- or is your feeling that like, look. This is just something that's going to be confusing to people because it is by its nature pretty complex and, you know, we'll just work on communicating, you know, separately from that? I guess I'm asking, is there a strategy to -- you know, to talk about the importance of this in a way that people generally can appreciate it? >> There is, Josh. And Jim wants to jump ahead of me. He's trying to pull rank here so go ahead, Jim. Then I'll fill in if need be. >> I would say you're looking at our notes in terms of what we see we need to do. What we provided was really some of the concrete actions but you're absolutely right. What we want to communicate is what is going to be different and how will people know and most importantly, what is it we're trying to achieve with C.D.C. moving forward? We've been working on clear goals and objectives to be able to communicate both internally as well as externally about why this is important, why is needs to change and being careful about it and then highlighting strengths and where there's great action occurring. You heard from Deb and where are areas for improvement but that whole idea of being very clear about it, you'll see something very soon shortly and that's -- >> I'm asking something slightly different. Just really quick, slightly different. There are certain projects that C.D.C. is working on that really matter to people. This isn't so much about the reorganization itself but something that really matters to them. Will their children be able to be tested for lead poisoning? Will the water in the community be safe? Is there a way to connect -- you can wave the nature of the reorganization, you know, a hundred different ways and people interested will be interested. But if you can say we're doing this to be better at these ten things that matter to people, is there a way to communicate it at that level so people can appreciate in a way use this as a vehicle to enhance appreciation of the work that C.D.C. does? >> Yeah. That is such an important point. It will be a good point of conversation, I think, if you're having Kevin Griffiths come in and talk about the communication strategy. We have had conversations about this, about packaging information in clearer ways that resonate for different key partners, including the American public and that's not just the work of what are we doing around a response but it's also the internal work. What are

those good news stories that actually connect to the American public and lift up the contributions that this agency is meeting, is making that frankly from my vantage appointment, are just a little too invisible? Not enough that's been done in that space. I can understand 15 reasons why but we actually need to put more emphasis, I think, Josh, what you're talking about. There's a connectivity that needs to be made there. And so I think if you flag this and raise it with Kevin, first of all, it's on his mind but second to hear it from you will be just as important for him to hear it. Agree with you. >> We'll go to five after the hour? >> Sure. >> Julie? >> Thank you so much for your presentation and your work. You give me hope how you approach the assessments and where you're going is remarkable. I think I heard through your presentation there's a clear acknowledgement of the speed at which information is shared now versus five years ago, ten years ago and so you're really -- your plans really acknowledge recommendations and also the plans really acknowledge the need to get information to the public more quickly and also differentiating the kind of information that needs to be given to the public, to the health care guidance, to researchers and that's critical. It give DAIB it -- it gets to the research. I wanted to just kind of take what Jill said a little further. I think this porous engagement with partners is critical and essential and I do think it actually happens and has happened for years but very informally and maybe not consistently and not in a standardized kind of way. I think the other issue is it didn't always happen at the right point in the process. So as guidance is being developed, it could be that these partners could be engaged that the point or prior. I remember as a state and local health official being notified about guidance after it was done rather than weighing in and contributing to the guidance as it's being developed. In as much as you don't want to engage with the core partners in the midst of the crisis, you want that on an ongoing relationship prior to the crisis. It's also a matter of inserting them at the right point in the process as well so I would want to move that up as a recommendation as you move forward. A question to you that may not be relevant, and you don't have to answer this, there's a reference to an executive board that rochelle as director has to move forward. The work you're doing is so important. It needs to continue with speed and I just hope that doesn't interfere with your ability to get things done. >> Good point and the intent is not to slow it down but rather to garner some efficiencies and I would say across agency engagement, create some porous boundaries so more to be said on that going forward. But with your other point about the ensuring pore usness around engaging with outside audiences, there's so much that can be learned from our partners from our parts of H.H.S. So for example, we don't have to start at square one on every single new direction that we're moving on. So in some of the areas that Jim has shared with you on the priority action teams are focusing on, where they're taking and working to make actionable the particular pieces of his report, there are engagements with external audiences, for example, that C.M.S. uses and so we're inviting C.M.S.

in to talk with us about how they -- with the office of general counsel, how they engage their external partners on the front end of a process before things go in formal guidance, development, et cetera. So there are strategies to use here that are being used in other parts of H.H.S. and pull them in and put them to work for the work of this agency. We've also invited in with some of the priority action teams F.D.A., H.R.S.A., N.I.H. because from those sister agencies, there are things that they do that we should at least consider here and where it makes sense, adapt them to the work we do. Just as they can learn about what this agency is doing in a number of key areas. This is not all one -- I was talking with one of the senior leaders yesterday in Washington and I said, here's how we want your engagement with this particular set of work in this agency. And guess what? You're going to learn something from C.D.C., too. So this isn't just come help us. This is keep YURP -- your ears open because it will probably improve your performance as well. I would like to say there's so much opportunity to leverage the assets from across H.H.S., it's a very big agency but from where I sat historically, you can see wonderful things happening but the best practices don't move through to inform other parts let alone within C.D.C., for example. So it's also creating a mindset that it's OK not only is it OK, we should expect that of ourselves. We're going to learn from how other places operate, even,000 they ENgage with their external partners. >> One point that you must have read my mind about the report itself. When I started, it was primarily folk used on response but what quickly became apparent to me was that there were things that could have been done before the response and there are things that need to be done after the response in terms of being able to move forward and one of those is building partnerships because in the long run, that's what you need during a crisis if you're going to be successful. So building those partnerships beforehand is so critically important. It's possible but it is hard to build really trusting relationships in the middle of a crisis and so to the extent that you can do that and just build it into your D.N.A., it helps you when you run into something that's challenging because you have that relationship, that partnership, trust to be able to do it. So a lot of recommendations really are about how C.D.C. can move forward not just in emergencies but also in non emergencies which will actually set them up to be good in emergencies. >> It was really helpful to hear your point, too, about how of course a lot of this conversation occurs and communication occurs but when it's person specific, when it's tied to who I know rather than to a built-in place where somebody can always go to get information, regardless of who is in that position, it's really helpful for me to hear you articulate that point again. Flagging these issues for us keeps them – helps keep them front and center. It's a little bit of what we're trying to focus O. Jim and I are here to help to try to support this agency's efforts in C.D.C. moving forward but at the end of the day, this agency, its leaders, the employees throughout the agency are who -- what own the success of this initiative.

It isn't us. We're here to support the tremendous expertise within the agency but this is -- we're looking at quick wins and longer term process improvement, et cetera, and at the end of the day it's going to be up to, as I said, the wonderful agency leadership across the agency to make this happen along with their employees. What we've tried to share with you is what we're working on with them. So we might be -- I'm making that point because we're the spokes people up here but the real work is being done by the agency. >> This is such a rich discussion and we have not much time left, for the remaining questioners, if you could keep your comments brief as we can make sure we get to everybody. And I have octavio and then Daniel and I'm trying to reserve one question for myself. We'll see if we get there. >> Again, thank you for those presentations. They're very helpful. My question relates to the -- what I would say is clearly a goal about increasing the speed of communication. So my question really is -- and I don't know if you're the right people to ask it of. I don't know. But how will -- what do you imagine the strategies will be for resolving the tension between clarity, accuracy and speed? Because it sounds like -- I'm sure the C.D.C. wasn't trying to be slow before but they were trying to be accurate and one of the problems is that in terms of dealing with the public that has essentially no tolerance for either nuance or inaccuracy and, you know, I wonder, how will that be resolved? It's a great goal but some of these concepts simply are not -- they're not simple and, you know, it is disastrous when you have to backtrack so what's -- is there – how is there going to be a strategy for dealing with that? >> So we thought about this. I had to listen to Jim speak to this issue a thousand times. >> We do have a communication center this afternoon. >> Deb, you may want to jump in, too. >> Bring it up with Kevin and it's one of the tensions within the C.D.C. of course because there's a mantra to be right and those are sometimes mutually exclusive. Fast, quality and cheap? It's hard to do two of the -- the analogy is not good but I think that's part of what we're trying to work through is how do we do that in ways that make sense. We don't have the answer so that's part of what we're trying to work on. We would really value your insights in terms of how to get there. And we are going to utilize as much as we can and I would encourage the whole idea of human centered design as they're developing communications and other things to really work with people, do focus groups, have conversations because I don't have the expertise. I'm not sure the organization necessarily does yet but one of the recommendation $ that they develop that expertise. >> One thing that's going to be really important is making sure that the communications people actually do understand the science. >> Yes. >> Because they may be experts in communicating simply but if they don't completely understand the science, it can be disastrous. For example, neglecting the role of sexual networks and talking about monkey pox and other S.T.I.'s. >> Absolutely. And when you talk about porous boundaries, I think it's also within the organization we're stressing that, too. The policy people, the communications people, the

science people all need to be in the same room talking with each other, making sure that -- and then of course, with outside partners and the public. >> We can continue that this afternoon with communications. Thank you for raising that. octavio? >> Thank you. And thanks to Mary and Jim for a great presentation on moving forward initiative. My question is more down in the organizational behavior and how we actually change the culture organizations. What I've seen unfortunately, some organizations and I'm hoping that's not the case. You guys have given this good thought or are working on it. Actually as you very much have talked about quality improvement, long term make it part of the D.N.A. so thinking about the H.R. processes of the C.D.C. itself and how they need to be modified to be in alignment with the moving forward initiative, think about onboarding and also even modifying performance evaluation to ensure that actually behavior is being monitored and changed over the course of time and so it really gives -- gets to be part of the D.N.A. as Jim mentioned, especially when it comes to diverse ILT, equity, inclusion, accessibility and even the cross unit collaboration you've been highlighting so just wanted to hear what your thoughts are on that. It's more in the weeds but it really is an important component changing culture. >> And there's a lot of attention in this space. Robin, do you want to speak to this? You and your team is point on this. >> Absolutely. Thank you for the question. There are a few things that are happening. We started a few months ago looking at how we transform our H.R. processes and a lot of work has gone into that. We recently had an all employee webinar that spoke to the changes that employees would start to see as well as managers. What the expectations might be of management officials in terms of how quickly we move through the process. When it comes to D.E.I.A.B., we put belonging in there as well, we have a strategic plan that has been identified. Each C.I.O. has written an action plan to support the strategic plan. The action plan specifically is a plan that was designed, coauthored with the employees of each C.I.O. so they're the different level of accountability there relative to if I'm saying to my employees what I'm going to do based on your feedback is quite different than just pie in the sky. It's specific to the organization and specifically what they might expect. And we have a disc which is our executive steering committee who is going to be then having frequent communications requirements about how the C.I.O.'s will then share with the employees the progress that's been made and you know what it's like to stand in front much your employees saying something has happened if it hasn't happened so it's really a different kind of feel associated with that. But all of it is designed to change behaviors linking our recognition as well as how we think about promotions and how people get development at our organization will all be linked so that we can sustain the behavior over time. This is a really, really important piece for us because we're -- even with the strategic plan, the plan was sent to every employee for the opportunity for feedback so we can make sure we're focused on the right things. We can't do the ocean but those things that are important to employees, we're trying to move in that direction.

I hope that answers your question. >> Thank you. An issue to be continued. >> So thank you so much to Mary and Jim for that excellent presentation. I was delighted to hear about health equity being across issues and you've been thinking about it and being intentional about. In our health equity working group, you know, that was one of the areas that we sort of flushed out and we talked about it from community based organizations, creating centers perhaps to help elevate them in this process so my recommendation would be that we really promote a more inclusive and equitable approach to these results based partnerships moving forward. A lot of times there are entities that are serving racial and ethnic minorities that have not been part of this effort and they would like to be part of this effort right there, trusted. I think the reach program is a great program here at C.D.C. that could be leveraged for such moving forward. >> Could I just say, that is such an important point and appreciate any and all recommendations that come from this group in that space. We do have specific conversations where – and have had them at different points in time just to give you an example, most recently, conversation about the tribal advisory committee, for example, that is an entity within C.D.C. kind of mirrors the secretary's travel advisory committee at the H.H.S. level and the extent of which some of that work is inclusive of and focusing on the views of the national Indian health board, for example. So anything and everything you can give us about here is how you should executed and bake in those relationships and even identifying examples of relationships, we would welcome that because there's good work underway, there's a lot more to be done. Yeah. Thank you for flagging >> I would say especially for C.D.C. given that a lot of their grants go through states and localities, how do you make sure they reach the populations that you are most in need or need the resources or are underresourced and can't apply for the grants so that's something we're looking at, at my home agency in H.R.S.A. but if you could provide some additional feedback and input how to do that, it goes back to what robin was talking about, incentives. >> In other agencies across H.H.S., including at H.R.S.A., there was an implicit outreach to target -- to target tribal communities because in many cases, they cannot begin to compete financially with those organizations that have got somebody on retainer to write the grant proposals. That playing field is so uneven, it's painful to see. So we're very explicit at H.R.S.A. about helping provide technical assistance to those organizations that from the start of preparing a proposal are left behind. So any and all suggestions you've got, we welcome those ideas and we'll try to drive them in. >> We are way over time. >> fine. >> No, no. You have two more minutes. Last suggestion I wanted to make and this comes from the honor I've had working within this agency including the office of the director, is that as you've been saying, some of these cross agency initiatives are probably the most important things to focus on. In an agency like C.D.C. that are most difficult to get done. Most people at C.D.C. work in a center in a division, in a program and spend most, if not all of their time working with people

in that same place. So the opportunities for these cross connections to occur are difficult at best. While people are well intentioned, I'm wondering if you thought about the processes and structures that could be set up to create in an ongoing way those connections between the different parts of C.D.C. because that's the only way functionally from a culture standpoint that we can be effective in achieving these cross agency changes. >> You must be seeing our notes. That's one of the things we're thinking about, too, and I look and I see Jim. How do you dig deep and make sure you have that sort of expertise and knowledge but then how do you think across because both are valuable but it's really combining those two because you need the program expertise but if you don't have that cross cutting, it's not as effective. I think trying to look at how we can create incentives within the organization, put it into performance plans, part of the expectation is that you're not just successful where you are, it's also helping the agency, it's also helping our partners, just any kinds of suggestions about how to build that kind of cross collaboration and you've heard Dr. Walensky, several of her principles are accountability and collaboration and I think those are really essential in terms of how do we ultimately get to that place. I think most people want to get there. That's my sense. It's just challenging. >> I would just add, it's funny that you raise that because we were just talking with the director this morning in light of some work that what are the cross cutting themes and how do we engage different parts of the agency. That isn't easy, of course, for any organization that has any degree of complexity. Certainly is not easy here but we have our eyes on it there, too. If you see strategies, processes, structural components that you think, here's something they ought to consider, we welcome that. We've talked about a lot of issues this morning and I wouldn't want to leave anybody thinking, they solved for that, they solved for that. Hopefully what you're hearing is part of what you're talking about is very much on our minds and we're working the issues but every strategy, idea, emphasis on this, we welcome that input. This is a very stuff slot. As Jim said, we know the pressures that are on the senior leaders across the agency. The director has asked for briefing on C.D.C. moving forward and she gets them and she gives us her direction every week. This is a high priority for her. So we may be talking about but we're talking with her weekly. This is a very heavy slog given everything that the leaders and staff are expected to do. So what we can guarantee you is that our eyes are on much of what you've raised today but getting to good solid solutions implemented across the agency is where the rubber meets the road on this and any thoughts you've got and ideas for how to do this and do it even more effectively, absolutely welcome. The answers don't reside just inside the agency which is why this group is critical >> Thank you. We'll take you occupy that. Thank you for taking your time today, going over. We really appreciate it and especially appreciate the work you're doing. Look forward to it to continuing to have these discussions. >> We're happy to be here. Thank you. >> thank you. Wow. OK. I almost feel like applause but it's tough to have applause on zoom

as well. So imagine virtual applause. Great. Thanks, committee, and staff for the very, very productive morning. We are over time. The good news is that we have some free time in the afternoon looking at the schedule so let's go ahead, John is agreeable, take an hour for lunch and return at 1:15 for the -- 15 minutes after the hour. Thank you. For the -- I should know that living on the west coast. Thanks. For the health equity work group report. We'll see you in an hour. So with that, I will hand off to Daniel to get started. >> As many may recall, the CDC leadership asked to establish a health equity work group. There were four major focus areas we were tasked with. One was systems that monitor racism and other drivers of health and health disparities. Strategies that establish and sustain anti racist systems of public health. The third was policy levers and of course number four, multi sector partnerships that accelerate. With extreme experience at state and local public health agencies, non profit organizations, and academia health care, philanthropic. The first is how the CDC policies and programs can, active engagement and eliminating health inequities. The second was how it can align and restructure its internal policies to maximize the ability for staff and partners to address health and equities in their day-to-day work. And then the third, is how CDC can elevate and expand its activities to address the most upstream factors and their consequences. So you see that we took those three areas, we formed three task areas to really delve in to those areas to flesh them out further in terms of the action steps. And then ultimate recommendations. The task area one enables and ensures the meaningful involvement of agencies in community making. The development of health policy, program implementation and evaluation. Task area two was tasked with how to align and restructure so as to maximize the ability for staff and partners to address health inequities. And the third is looking at actualizing and expanding the focus on upstream activities and their consequences. Task area was leadly myself, two by Monica and three by David. As you can see, they're outlined on the slide. >> Monica: The last time we came together, we spent some time on that call. Next slide. Removing the moving forward resources publicly available on the CDC website. We were pleased to see there may be potential alignment in terms of the deliberations and conversations we were having. I was really excited to hear Dr. Walensky talk about a culture of action. We heard that throughout Jim and Mary's updates to us on the moving forward work, the strike teams and the patents and the all of the work is in service of being very action-oriented and addressing different challenges in really timely ways across the agency using this whole CDC approach. So since then, the work they did, we found there was alignment in terms of the creation of this one-stop shop, recognizing that we were curious about how CDC might be defining what external partners would include beyond state tribal, local and territorial health departments. And then across all three task areas we also recognized, and I hope you saw this in the action steps that were in the report, the need to make real structural changes. And ensuring that it did not become the

work of one office or one program to carry the ball forward on the health equity activities, but it had to be something that became part of the fabric of every one's work at the agency. So we will use this as sort of the context and definitely recognize the sense of urgency in terms of how we're moving ahead with these action steps. Next slide. Because it is an 11/12 page report, we wanted to spend our time with all of you today focused on the last piece, which are the actual steps for consideration. Recognizing that we are still in the process of trying to streamline and do some editing on the background section, the challenges and obstacles, and the driving principles that drove our conversations and the creation of the recommended steps. We did have a discussion about whether we just sent the action steps by themselves, but we really did want the ACD to see the full report because there was lots of rich conversation and discussion throughout the summer months when we met and in between those meetings. And really using the guiding principals to help us remain focused on the goals that we hope are reflected in the action steps. We will go through the task area of recommendations and we will start with Daniel on task area one. >> Daniel: Thank you to every one who participated and helped us develop these. The first action step focuses on CDC, incentivizing equity and its funding opportunities and funding to non private organizations that include clear and sustainable approaches. To realize this, the members recommended four specific steps. First, incentivize funded organizations across several areas including supporting ecosystems that spur communities to begin and progress on their health equity juries. Second, maybe applications for those less challenges for organizations that service economically and socially marginalized communities to complete. Third, create centers to support throughout the process. Sort of modelled after the HR S-A opportunity. And then fourth, providing funding and resources through systematic and equitable processes. Next slide. The second action step focused on CDC building and strengthening relationships between C-B-Os and state public health agencies. As we know, a lot of funding or the majority of funding for the CDC goes to state health departments and doesn't necessarily trickle to the C-B-Os. We want to promote health equity, strengthening efforts to promote positive effectiveness and resilience. And third the then action step was CDC should elevate the office of minority health and health equity to the office of the director. And adopt and implement theories of change for achieving health equity by impacting systems and structures long term. Coupled with that is the CDC strategies should provide assistance to C-B-Os that are evidence based to reflect emerging or promising practices, especially for population groups who do not have evidence based practices. Next slide. Monica: So task area 2, what I found refreshing about the earlier discussion on moving forward was a lot of conversation on how do you translate data in to action to support equity and look at the results in the impacts of the work that the agency is supporting in communities. And so these are more internally focused in terms of the how, the approaches taken to compliment what Daniel just outlined in task one

recommendations. Action step 4, it really is about developing a culture shift that's driven by including diverse groups and setting policies, science and agendas in meaningful way. In your full report you will see we recognize CDC plays a critical role in developing programs and they do have vast federal resources that can evaluate strategic actions on the ground across communities that are really tackling the root causes of health inequities. We also recognize that there is a need to shift agency culture so that this work becomes accelerated beyond a single center, division or program, but one that allows CDC staff across all levels. So vertically and horizontally across the agency to examine how they see themselves and the work they do to promote effectiveness and accountability in ways that work with partners, which includes not just the governmental public health systems but community-based organizations. Action 5 is related to building equity in a policy approach, in the way the resources, not just the financial, technical support provided by CDC to communities. So again, we are strongly urging the CDC divisions and programs that they all be required to center equity across all grant making communities including grants, cooperative agreements and other ways in which you disperse and allocate your resources. In a summer conversation presentation with colleagues from a state health department, they recognized and appreciated the flexibility they received in their COVID equity dollars to provide, for example, advanced payment and other ways to braid funding. As we all know, state and local health departments receive many diverse pots of funding. So being able to really have the flexible to braid and layer those resources in ways that support the development and maintenance of cross-sector partnerships, particularly with a community based organizations often not well resourced as other organizations, to tap in to these funds and technical assistance are really necessary to address the different social determinants of health and communities that impact over all health. We also are recommending that the CDC ensure that there is flexible and sustainable funding to developing and maintaining these cross-sector partnerships and relationships in communities. Because as we have heard throughout the day, these are relationships that need to be developed before crisis and emergencies. And this takes continue vigilance to see these relationships and seek out relationships if lacking. And we know there were many opportunities through COVID that state, local, territorial were able to explore and approaches to work with community based organizations and community power building organizations to be extensions for those public health departments. In this action step, we also wanted to elevate that CDC processes should work towards figuring out opportunities to provide direct funding to certain intermediaries so the resources really do go in to those communities most impacted. Action step 6 is related to workforce development, I would say, in a nutshell. And it really is recognizing that there are already systems in place to train up project officers across the different CIOs, but really working in a more intentional way about redesigning training materials that

elevates the importance of grant making, and the role that project officers play in providing support to grantee partners. So again, going back to this culture shift, really lifting up the importance of building a culture of trust among CDC project officers to support a shift from a mind set of being subject matter experts or specialists to the important roles they play as coalition builders and thought partners to communities. CDC should continue to develop continuous training and workforce development for current and new CDC staff that provide concrete examples or best practices for integrating grant making and TA in program and NOFO design. And finally, under this action step, we are hear to Jim and Mary talk about this and also Robin, that CDC should talk about building equity in to your management systems to incentivize approaches for working with community partners. And finally, in this task area the last action step involves the ways in which CDC should work across program areas to develop communities of practice and action to support increased opportunities for peer to peer learning and sharing. Again, going back to the agency as a learning organization, we know that CIOs have offered different examples of way they have been able to center health equity in to design and allocation of funding to grantees, but there might be limited opportunities for creating more intentional ways to share those learnings across areas in real time ways and to encourage peer to peer work. And finally, under this action step, the felt that it was important that CDC should also explore ways of including workforce development in both internal and external efforts. How can community based efforts learn what you're doing internally to train up your workforce in integrating health equity across the different ways in which you do business. I will hand off to Davis to walk us through task area three. >> Davis: As we all know, public health is organized categorically with how money is allocated to how health departments at the local level are organized. And so the hardest thing to accomplish public health are the things that need to cross the different program activities and public health. As you know, and probably no issue rises higher on how to work across program issues around equity and health equity. Those are universal at the community level and we can only make a difference in we recognize that's the case and we organize ourselves despite the categorical nature of public health in to programs around measurement of equity and more importantly, activities to create equity in ways that cross programs. You have herd from task area one and two to do that. Task area three in particular said as far as what we're doing relative to how we measure and how we intervene at the community level; that we are strongly suggesting that CDC needs to take an agency wide approach and a system-wide approach in order to make that happen. That's what these two recommendations say. The first is around measurement, and it does say that the approach needs to be agency wide, but we dive down deeper in these to say it is easy to say agency wide, but what does that mean? What does that specifically,

in our minds, suggest that CDC needs to be doing? So there are two issues in particular where we are suggesting that CDC needs to take system wide leadership in the approach to equity. One of them is in synthesizing. What is the state of the art out there around measurement that collected in academia the health system and at the community level? Let 's bring that together in way we can all benefit from knowledge that right now is some what distributed. And that measurement analysis needs to be qualitative as well as quantitative and informed by the diverse community narratives out there. That is one activity. The second is to initiate a process in order to bring more coherence to this to see if we can't begin to identify and use field tested measures that are as consistent as possible across programs and jurisdictions, recognizing they need to be developed in close consultation with the community. And that the approaches at the community level need to be individualized. But still, let's look to ways to make it as easy as possible do in a coherent way. The third piece of recommendation for CDC is to say, you know, traditionally in public health we adapted a health disparity approach to how we define problems. That needs to be supplemented and complimented by CDC leadership to develop in addition a more comprehensive set of indicators that includes asset based solutions and solution-based solutions. So including that to help us move forward. What we come up with respect to measurements will not be of value if it can only be connected five years after the fact. So as we're thinking about measurements, we need to think and identify and develop measures that are timely and that are locally available optimally, potentially by tapping in to some of the big data out there to begin thinking about what are some of the sources out there not used in public health to supplement this. And then finally, and maybe most important and difficult, we need to ask on this by promoting and enabling through each and every CDC program finance. To make these measures real and actionable at the local level. There is money within our public health system right now, not dedicated towards issues around equity and measures of equity, but taken an agency and system wide approach that needs to happen. And in a system way, probably more important is what will we do? So we are encouraging CDC to initiate a coordinated agency wide approach to develop and integrate methods and strategies to influence drivers of health equity across the entire range of public health programs at CDC at state and local level. This would be facilitated, we believe, by aligning and integrating internal organizations at CDC so the leadership of health equity and social determinants of health activities are talking to each other and synergizing on each other. We believe that this could be JumpStarted by perhaps requiring programs at the state and local level to begin to conduct that analysis of what are the drivers of equity that are most important in a particular public health program. And begin to define where the opportunities for action are. And then, again, using program funding, not expecting necessarily new line items, to begin at the program level to develop

programs and approaches to influence those key drivers critically in close concert with the communities affected. And then to finally and most importantly, make sure that we're defining what success is. Recognizing it will be slow, capacity building, and include measurement in our program activities to know whether collectively we're making progress in the directions communities have decided are the most important. So I will get off my soap box. It has been easy to work with these two folks, but there is a real opportunity in front of us as a committee in front of CDC and the community health system to really do it right. There is interest, energy, financing available to actually begin to make a difference. >> So at this point we will open it up to comments and questions from the ACD members. >> I am curious about the last part. A lot of suggestions about data collection analysis and availability around these equity issues. I know you know a lot about it occurs some may be collected, but are not allies or reported in a way that it is focused on social determinants and equity. I am thinking about the N CD H data. There is a lot of data collected on the population, but a lot is not timely. You really focused on timeliness. I think it would be helpful to the agency, maybe, to give that some thought. Is there existing data that could be repurposed for this, but two, what is the timeliness needed? It will not be like an epidemic, you need the day-to-day, the exact numbers, but probably to be four years or five year lags are not good either. But also, are the data systems good enough? One of the things I think I have been worried about increasingly every year is that a lot of those traditional systems were designed around a time when people had land line phones and could be found that way. Are there inequities in how that data is collected due to the fact that people don't have those anymore, maybe people displaced by storms, living in mobile homes. I think that is well worth considering. There could be some, you know, efficiencies in using those systems, but maybe some of those systems are creating some inequity because of the fact they haven't changed over the years in ways that allow -- or maybe they never did. I am thinking, you know, Latin X or Asian populations, other populations, rural populations. I think it is all worth the consideration. I think the working group can do that or come up with recommendations for the CDC on how to do that. >> Really well said. I am looking at a couple of people on the group that have a lot of work on this. I agree with everything you said, and I would also I think public health in general has been slow on developing ways to efficiently and rapidly measure community indicators of health. We placed a lot of emphasis, but since it is influenced by the places we live, work and play, some additional attention to the community level indicators of health, and things that are potentially influence /-BL need to be added. >> I think to that point, David. I worry less about the timeliness in that sense, because I think what we know now is that about those shifts over time, the shifts and the way they impact health and well being takes place over time. It is not going to be immediate. So yes, for instance, the pandemic immediately impacted certain communities

because of structural inequity and racism, but being able to capture the structural racism side of that wasn't necessary because we know that it is historical. And we can look at racial lining, red lining, to look at what is happening and inform us on what is happening in a given moment. But then, I think there are important opportunities to capture what is happening in real time. So thinking about how to do that in a way that is unbias will be certainly important. The other thing I wanted to lift up is I think there is a lot of opportunities to think about -- and I don't remember, Lynn, if this is what you mentioned, but data not necessarily thought of or used in this space to think able social determinants, enequity. It is already there, so certainly that is some of the work my team is doing. We're looking at Zillow data, all sorts of data sets that were never made for these type of analyses, but I think can be incredibly informative. It means we have to think about how we want to partner with the private sector in ways we probably haven't before and be willing to come to agreements. But even within the CDC, I think there are opportunities. At our last meeting I learned about the environmental justice index. And that index had such importance for another project that I was working on around maternal immortality and measuring impact and maternal death. That is a CD project, we're working with the maternal health group and ACOG to develop this tool to leverage the way to include that work. So I think even starting from a survey, some sort of understanding of what is already happening. I think we would be surprised what is already happening in this space that we can leverage and build from to help inform this.
>> Excellent. Comments in your role in data or work group surveillance cochair? >> I don't think I have anything to add. I think Rachel and Lynn said what I would have said. I don't have anything to add.
>> There is one thing I did forget to mention that is in the report. One additional role is to recognize much of the data we may be interested in, is not as you said, public health data. So maybe in other government agencies, transportation, housing. So CDC has an important role, leadership role, to make sure there is a leadership here connecting with those other federal agencies to bring both for measurement standpoint in to the fold. >> Josh: Thank you for the tremendous work by the group. I want to focus on some other recommendations on the data, and it has to do with the discussions around direct funding of community based organizations. There are some inherent intentions that I think you are grappling with. Some of the ideas I really liked. Some of the language made me nervous. I will start with the nervous, and then what I really liked. What made me nervous was the idea when state and local governments get it, they take a cut. The state and local health departments take a cut. Ideally though, a lot of this work is getting lead by a coalition at the local level, so there's some tension between saying, well, the relationship that a community-based organization should have, it should be with its funders, CDC. And the idea that we want things to be lead locally with diverse coalitions figuring out what a community should do. Because it is

hard to do that one grantee at a time from a national level. And if you just see state and local health departments as somebody who takes a cut, rather than a potentially convening group that really can bring together community-based organizations and others to solve problems, then I think it undermines what state and local health departments can do. And I say that with some experience when I was working with community based organizations that were entirely focused on their federal funder and were very hard to work with at a local level as they really didn't feel that engaged. I think it is more complicated than just saying CDC should fund more community-based organizations given the work we need to do should really be organized locally, or the work that needs to happen. What I really liked about the report is that you didn't just say that, I mean, there are themes that it sounded like that, but you had a few ideas I really wanted to pull out and say I think they're great for dealing with this tension. The one I particularly liked is that you have strong expectations for state and local public health departments to lead those kind of engaged coalitions, but if they fail, early in the grant to do that, then you say you tried, failed, we will give the money directly. So you had the concept that there could be a convening role, that it could be something more organized locally, but if it doesn't happen and the state department will take the money and not share it, then CDC has to step in. I really liked the sharing of the grant, what is happening locally and CDC together. Another thing to think about in that tool box on how to thread the needle, is support from requirements that grants to local organizations align with local processes happening. The relationship isn't just with CDC but the locally. They're demonstrating support as they're applying to the CDC for funds, that is part of the expectation and maybe they have a letter of support from a local coalition that the health department is a part of in order to get funds. But I would just caution against the idea that the steps the community organizations is almost opposed to funding through public health agencies, when it is often through public health agencies that you can get a lot of alignment to solve problems at the local level. Thank you for giving me the chance to say all of that. >> I really applaud the people instrumental in drafting that report. I just wanted to add as a corollary, as we at CDC moves forward, we should probably give some thought, as should CDC, to considering who exactly the community is. What is meant by community exactly? Are those racial ethnic groups; are those people who define themselves in a certain way by certain behavior? There is very direct discussion of community-based organizations, but not every one in the community is necessarily represented by CV Os. So I think it is something in addition to think about in the future as we move forward. Thank you for that. And one more thing. In addition to thinking about who is in the community but also how exactly do you work with members of the community when they're not in those very specifically defined groups? Because I think it can be more difficult. >> My comments are actually along the same line. In addition to thinking about who is community, I want to push back on this notion of how the money -- where the money,

where the dollars go. I think what we saw in Minnesota during the pandemic is that the grass roots community organizations, for lack of a better term at this point, were more effective in deploying resources and supporting folks with testing and things like that than our department of health was able to do because they didn't have the authentic connections and trust built up. So I think that it is a both end. Some instances it may be our local public health agencies who we need leading the work, but we also need to step back and say that is not the right agency to do the work. Another example we have seen in Minnesota is the power of mutual aid in after math of the uprising after George Floyd. And the ways that community was able to come together with resources. And a lot was not in a formal way. So figuring out from a measuring standpoint on how to capture that, but also in thinking about how we deploy resources and money and funding in those spaces has to be a part of that conversation. It is one my team is thinking about at the University of Minnesota as I lead a center where we try to get those dollars out the door in ways that feel virtually impossible because we have a lot of structures and bureaucracy in place. I would love to see CDC being the leader and shifting that and doing things differently and being creative and taking those risks that perhaps other institutions can't do right now. >> Yes, I want to agree. It shouldn't be the funding to community base funding or to state and locals, it should be complimentary. There is a good example of that happening through the immunization work for COVID. There was a /PA*EF program which got funding from CDC to an intermediary that then got funding to organizations while states and locals did the same thing and they were complimentary. This concept of the organizations getting the funding as well as the governmental agencies to work together is really important. And if the funding is coming from CDC in both ways, you can build that expectation. I think it is important. It shouldn't be either/or, it should be both and. I want to step back, because what I wanted to lead with is you started off the conversation in terms of us getting conceptual agreement. I would say I am in concept really supportive of the action steps you have listed here. I feel like they're really strong and conceptually very supportive. There are some tweaks I would suggest in the recommendations. One is number two, part of task area one. You mentioned specifically CD Os and state public health agencies but I would still state local and territorial. They get funding from CDC. They're opportunities for influence. The other is No. 6, which is part of task area 2. I don't know that I would specify project officers. I feel like that recommendation should be toward all CDC staff. All CDC staff should be able to benefit from training materials that elevate eligible grant making so everybody understands the importance. And POs for sure, but I also feel like it applies to other CDC organizations. >> Thank you. Crystal? >> Thank you for this. These are great responses. I wanted to go back to the conversation around structural racism and data. I am not sure exactly where this belongs, maybe task No. 3. But it is something I have been concerned about is how do we get to things that might not be readily seen in the data. I will share the example of imbedded racism

in tests. As we know, FDA is looking at the pulse ox similar /TERs when those are used under our skin. We know there are other ways out there when it comes to screening, yet I'm not seeing a dedicated push to address those. Partly because they live in a lot of different places. A lot of different effects. So it affects health racial disparities and outcomes. There is an opportunity for CDC to be an influential voice. Because preventative services and clinical screenings are not as effective if the tests are designed to be less likely to identify certain ethics and racial points. I wanted to make sure it got out there as part of the conversation. >> Thank you. That is something that leadership should take note of. Thank you for bringing that up. Are there other comments? >> Lynn: Well, I mean, I have just been super inspired by all the comments. I just want to toss out some other ideas. One thing that occurred to me, especially after what Josh said, that is I think there has been this kind of assumption that some kinds of public health data originate in communities and flow upwards, others originate downward. Every few years hospitals have to do these assessments. Could there be a way for public health to standardize that to use that data to give information on these disparities. The other thing that occurred to me is the B RF process, which is we think of the risk factors, smoking or not, but isn't it a risk factor, poverty? Isn't a risk factor social determinants, structural racism, community stress? Now, that system has some of the same problems as the other systems I mentioned, which it is based on older ideas on how to get a representative sample, but still it is a way to bring forth information locally. It might also need to be overhauled. There would have to be a lot of participation in doing that, but it does occur to me that the whole paradigm of reporting up, whether it is about infections or what reportables could be applied to social determinants as well. >> On the point which I think you made that is interesting with regard to social determinants of health, we will be hearing in a little while from Karen hacker who will talk about the work we're doing in social determinants of health. Maybe we can ask Karen when she is speaking to try to address specifically the suggestion that you were just making about utilizing that in a way to would capture additional information. >> And if I could add a comment. Even the name that it is behavioral, which implies that it is something people choose, I sometimes feel like it should be renamed, the survey. To some, you know, that title seems that it is blaming people for risk factors. >> And Karen might come up with something easier to pronounce, too. Laughter. >> I don't see any more hands raised. I would like to ask Monica or Daniel if they have summary comments, and then whether you have a recommendation now for the committee. >> So I can start and I am sure Daniel will go off the observations I share. It sounds like from the discussion that there are some important points that the ACD members have flagged for us in terms of this tension. Definitely something we were aware of as we were drafting it, and I think it came up in some of the comments, the ways in which we phrase language around direct funding to C-B-Os. We're all in agreement the intention

is to support those communities impacted by services. We can agree it is not either/or. There is a role for local and state health departments to play. And the intention for this was to address some of the things we were hearing in communities where the state health departments were not delivering quality public health services and grants they were receiving from CDC. Just to put out there it was the spirit of the language, and to recognize it is not either/or. So we will give more thought to that. I appreciated the comment shared on how we give more thought on who community is and how does one work with communities that might not be engaged in or part of CV Os or non profit sector. So that is also something that came up in our conversations in terms of who is the community. I would say some of the communities that benefit from the CDC grants would identify themselves as the state, local and tribal health departments. Understand that is something we should look through and look at the language carefully. And then a whole host of observations and recommendations on data and the social determinant of health. I imagine in the presentation Dr. Hacker will provide, that this will also inform some of the rewrites or revisions. From my perspective, it does feel as if, although I don't know what the protocol is in terms of conceptually support at a high level for the direction we're going. My impression is if we can go on the record in terms of vote or whatever the process might be in order to support the action steps that Daniel and I and you are presenting so we can go on record. And also given the sense of urgency that the moving forward team has shared in terms of the work they're doing with the strike teams. And then hopefully come back at our next meeting to continue to share the revisions and how we have tightened up the language, and hopefully have more discussion with the CDC colleagues on the revisions. >> Daniel: I echo everything that you said, Monica. The robust dialogue we just had is a testimony to the great effort that we saw from the members and of course the CDC teams as well who helped in this effort. I will say that in terms of what we were focusing on, we're trying to bolster community engagement, prioritize of course opportunities for communities that have been /PHARPBL / TPHAOLized, that have been left outside and excluded from having representation at the table, for them to have an opportunity to meaningfully engage in the work this agency has and will continue do as it embarks on dismantling sexual racism and creating programs more assessable. So I do think the report and these action steps really help to move us in the right direction in terms of that. I echo everything said earlier, and I think there are some legitimate areas to strengthen that will be done and then hopefully focus on the full report. >> Thank you. >> David, just one comment. It was really about inclusivity, but he mentioned marginalized exclusivity. The status quo of the way public health comes through the states has excluded some very key component members of our communities. That is what we were trying to capture as well. I think the comments have already been said to that, but that's what my statement was. Thank you, David. >> John, any comments on how to proceed? >> John: The first thing I would say is I really appreciate being

able to participate in the meetings of the health equity work group and understand how much thought went in to this. I would also say that I really appreciated that you had a broad definition of the groups that were affected by health equity. And appreciate that the members of the group included a person with disabilities, a member of the tribal community, and that you incorporated those contributions in to the report itself. In terms of the CDC perspective on the way you are presenting the report, I also hear it as being more at the level of what are the issues to pay attention to? Where do we have the potential to make progress? I think that represents a charge to pay attention, and in doing so there may be multiple ways to do that. So in terms of hearing the discussion about the importance of state and local, and their relationship to community and community funding activities as well as looking in to what can be done around direct funding, those are things we should pay attention to. So I appreciate that's the thrust there, the key points are there, and that we would interpret that as rolling up our sleeves and figuring out where do the opportunities exist to move ahead. So thank you for offering it at that level, which then allows us some flexibility in terms of hearing what you have presented with regard to how best to implement that. >> Just to be clear, I appreciate the report and I was not suggesting it be rewritten, I just wanted to bring up points by CDC. Not saying anybody needs to go back to the drawing board. >> Thank you. So speaking personally, I think we all agree, and give a great thanks to our cochairs, Monica and Daniel, and the health equity work group for the work done. I am hearing from the committee support for the action steps and for Daniel and Monica's suggestions that these action steps now be translated in to recommendations from the advisory committee to CDC. I will say I think we should say that there is still support, but that in terms of the time emergency and importance of this issue, I hear them saying we should move forward now with this conceptual endorsement. And that we even potentially plan out our next meeting to have some initial response back from CDC on questions and issues they would like us to explore further. Would either of you like to make a motion to that effect? >> We make a motion. >> We can have one of you make a motion and one second. >> Is there any further discussion of this issue? If not, I will call for a vote. All of those in /TPA*EUF which would approve as conceptual recommendations. >> Just one other comment, because it wasn't mentioned that I can recall. I would like to elevate that because of the data and metric concepts, the issue of intersectionality and the importance of that because I think that is a key thing where a lot of key community members, from my perspective of work we do in Texas is being lost. We have individuals in different sectors not only maybe a minority or minorized individual, but also happen to have a physical or mental health disability. And those intersectionality issues are ones that I think the CDC would be really wonderful for us to elevate. >> So let's call the vote. All of those in favor of the motion to support the action steps from the ACD to CDC that are conceptual and those fleshed out in the report. All those in favor?

Any abstentions? Any noes? >> I feel like we need to take a break, but that's not what the agenda says. So let's celebrate, pat ourselves on the back. And then have a presentation from Jill and Josh on progress from the laboratory working group. Do a change of speakers here. This information is primarily information, although this group has been doing a huge amount of important work, and are not in a place quite yet to bring findings, but want to make sure that the committee knows what the work is being done and the process that's in place and whether you have any suggestions on the process. >> Good afternoon. That was an amazing presentation from the health equity group. I'm here to say watch this space, we're going to do one just as good. I will start out, it will be short, and then Josh will take over. Josh, it is great to see you. >> Josh: Thank you. I'm sorry I can't be there. >> Next slide. So the area we're focusing on at the moment is the terms of reference No. 5, which is on this slide. Essentially as part of a budget agreement congress requested HHS establish a task force to go back and look at the shortcomings of the first COVID test that came out from CDC in early 2020, as well as the policies, practices and systems that should be established to avoid further issues. So we're focusing on this one and HHS has agreed that our work group will be the task force. Next slide. This is a busy slide, but it is important to look at the language put in this congressional ask. So the text at the top is to look at the shortcomings and the policies and procedures, practices and systems we need to put in place. And clearly this addresses a lot of the work Jim and his group have been doing. We have divided these tasks, the top one and the two bullets in to elements, elements being scientists. And the first one is element A, and Josh has taken the lead on that. The second bullet which is CDC processors for the development and deployment of diagnostic tests and their on going operations including communities, electronic lab reporting with the other labs of the system, task B, C, and D which I am leading. And then the second bullet is back to CDC based on what we come with. CDC shall develop the agency wide coordination plan to developing and deploying assays. I think at this point Josh will take over. Watch the space, this is what is coming. >> Great, thank you. Team A as we call it has the charge of trying to figure out what went wrong with the task. This is element A, at the top, evaluate what contributed to the shortcomings of the task. Including laboratory regularities. From that assessment of what went wrong, then we pass the baton to team B and C to talk about what needs to be fixed. Next slide. This is our original schematic. We have a terrific team A, which includes people with just enormous amount of lab experience and quality assurance. The idea is what is the different factors that contribute to a great test, and where potentially could things have gone wrong? So that includes the governance of the laboratories, because there are multiple lab as every one knows that was involved. What was the process of them working together. Was there proper regulatory over sight? Quality assurance, and you heard Jim talk about one dimension, the final step of is this step working? And that was missed. That is something that was public, but there are other steps of quality assurance

too. So we're looking comprehensively at quality assurance. Did the labs have enough resources in terms of personnel and funding? Planning is another thing that could have gone wrong, were there adequate plans for dealing with having to make a task like this in the middle of a national crisis? The responsibility of the labs for different components of it, sort of related to governance, but this is sort of our teasing out of potential different factor. Was there unclear responsibilities? Was there confusion? The actual decision making, one of the things publicly talked about, is that the third area of the task turned out to be erroneous, it didn't work. It was not effective when it was run, it gave confusing results. But there was a decision made to include that in the task, which was a component of the task that, for example, WHO didn't use. So how was that decision made? And other key decisions along the way, what was the process of scientific decision making. There was a decision made that FDA would manufacture the test for the initial distribution? How was that decision made? Was it consequential to the problem? And then we have two other elements: One is internal communication. How the information moved around the CDC was, you know, was good information reaching the commissioner? And external communication, how was CDC communicating at that time about the problems? Because the confusion on what was happening contributed in some ways to other labs not knowing what they might to to help. This is the list. Probably what we will do is condense some of these categories as we go through the topics. What have we done? We explored a set of topics for each question we wanted answered. A lot of those included requests for documents, and we have been provided quite a few documents from CDC. And we had a terrific meeting with a number of CDC officials to explain the documents and answer other questions related to those topics. What we are planning to do next is pull all of that together, really try to understand the key areas of failure that lead to the tests not working. And then frame that, say these are the major issues identified and then that is the baton we hand off the groups B and C. We will have a day and a half meeting where we do that synthesis, and then what can we do to fix it? You heard earlier about one of the steps CDC has taken. We will look at the different issues that came up, and see what CDC has done and assessing whether those scratched the itch that was established by the e-view of what went wrong; or whether other things could be done or other suggestions that we have. So it is really kind of a step wise approach, what went wrong, are the solutions the appropriate ones, are there other solutions that CDC should consider, and then that gets us to the report which hopefully will be very interesting and a lot of discussion on the funding. What we're doing is adding up to not just what do we do to fix the problem, but what should CDC's approach be do developing and deploying diagnostics and communicating. Next slide. I mentioned we will have a two-day meeting we will be then working on a report after that. I think we're interested primarily in any feedback on this approach we have taken and any questions on the approach. As David said, it is kind of early to share the findings as we're in the process of going through everything right

now. But I do think that CDC has provided with some extremely important information. I think this will be a very important part for us. >> I just want to add that groups B, C and D will follow the same format that Josh has established for element A, essentially presenting a set of questions. We have experts coming in, both from CDC and externally members of the task force representing lab experience from public health, commercial, clinical, full spectrum. And have very broad experience, so we think -- I mean, Josh has had the toughest part in a way looking back. I have the fun part looking forward. The data section is one that I am a bit scared about, actually, because the data issue is not just a CDC issue, it is a national issue. And so we have to figure out how to present that in a way that is appropriate and constructive. And we also have to present a language that congressional staff is going to be able to understand. And I was reading the data and surveillance work group report memo last night, and they're not going to understand it. We have to think of a way to understand that, so we have a lot of work to do but it is going well. >> So thank you. It meant a lot. There are questions and comments from the committee on Jill and Josh's report to us. Just one comment. This may be best to answer. I do just want to remind us all that this particular aspect of the laboratory working groups is a little unusual for the advisory director. This is being responsive to a specific request from congress. And so in that sense, my understanding is the committee will ultimately work on the findings of the report. And those findings would be relayed directly to HHS and congress as opposed to going to CDC. Can you clarify that? >> That's true. It certainly can go directly to CDC, but in addition to that, because of the language you refer to, it will also go to HHS and HHS would have the opportunity to review it, ask any questions for clarification. And then following that process, HHS would be the one to present it to members of congress and staff. >> Great. If there is a question -- >> Yes, I was going to ask Josh is the fact that it is congressionally mandated, does that change the roles on how we view the report? Obviously the working group meets not in the public eye, but they will work on it, then present to the committee. But will the presentation be open like this? So our first exposure to it will be in an open meeting. I just want to make sure that's understood. I understand that as well. >> We would, throughout the process, completely comply with the rules and follow those as they normally would be followed, just with the understanding and expectation that in addition to going through that process, it would go through the parallel process at health and human services before presented. >> It will not final until it goes from the HHS process from HHS to congress? >> In fulfilling the congressional language, it would not be a final report. But in terms of ACD's presentation to CDC, it is a final report at the point that the ACD would vote in favor of that. >> Okay. So then after leaving here, then it goes to executive branch process that is not FACA covered? >> Yes. I think we're going to work out the specific timing of it, so it may be possible in a near final version from the work group, it is shared with limited staff at HHS to see whether there's preliminary feedback as well that could be shared with the work group

and made available to the AC A. We haven't quite worked out the exact timing, but we're talking with people at HHS to make sure that they're having comfortable with the process. And we have talked with people on congressional staff to make sure they're comfortable with the process. And understand what we will do is meet the the congressional language the same time we handle this report. >> If I could add one other thing in terms of my comfort level. I don't think it would be good for the appearance to be that higher ups in HHS have anything to do with what we conclude, but we're not attorneys. And it would be extremely helpful to me to be sure that an attorney has looked at this and the congressional language and make sure they feel we are fulfilling this. >> Our expectation is we would put this through the processes needed. That would include people that are on a regular basis working at both CDC and HHS with congressional staff and members so that they were comfortable that it was in the proper format and being handled appropriately. And we would also go through the office of general counsel to make sure we're fulfilling the appropriate comments. >> And I hasten to say, there are attorneys but they're not experts in this. >> Yes, you are pointing to two people that are here and we value their contributions. Thank you. >> Josh, did you have a comment? >> Josh: Just that when we started this process, this is obviously a very difficult issue, very painful episode for CDC. It caused an immense amount of frustration within the agency and far beyond. So we didn't really know the spirit for which this particular task would be received, but I think I can say the a person we have worked with, everybody really wants to figure out what can be done to fix the problem. And wants to have a candid conversation. We're getting to some important issues. I think to the extent that there is a question that might be going in, there might be some level on this, we have not experienced that. I think our whole team will say that. We're really focused on what the right thing for CDC to know about what happened is. >> Thank you. I would reinforce it has been fun to watch you all, CDC and the working group in action on this. Deb? >> Deb: I want to thank Jill and Josh and I have talked with both of them separately. What I wanted to say to the full ACD is at CDC, we're not waiting just for the report. We're looking forward to working and hearing what we can do better, but we realize there have been issues. So Jim and the rest of D-D-I and all of us have really looked at what we can do improve lab quality, safety and excellence and engaging with the work group. One of the thing I think will be helpful to get input on in December is not just what Jim has proposed around a robust quality plan, but also potentially what we found from the lab strike team around some structural changes to see if this might – when the ACD has its work group, some of the structural changes proposed would have prevented some of these issues. I think that will be helpful to get this group's input on. We really value this input. This is not limited to COVID. I said this in a different form yesterday, this is long standing issues that we're really diving in to and taking a systematic approach. So we appreciate the work group, but I did want to give kudos to Jim, and many others who have really rolled up their sleeve. I think that's why they have seen the transparency,

because we have seen these issues and we look forward to partnering. >> Thank you for that comment, Deb. I think at least all of the people in public health, but certainly at the lab level, we're at a critical point and diagnostics is changing dramatically, not just because of the pandemic but because of storage and technology, because of people expectations. People expect to be able to do point of care tips. What role does that have for public health reference labs and the CDC super reference lab. And so we're hoping in this report that we not just care about CDC system and what is needed for that. >> To be continued. >> We are almost exactly on time. And so it is my pleasure to have Karen hacker come up. She is the director of the national center for and also been Tennessee chair of the CDC's task force on social determinants of health and has done a great job. She has been great in bringing this issue forward and drive progress. We have asked her to speak to us today on this initiative and how it affects health equity. >> Good timing, considering the last conversation. I will talk a little bit about what we're doing here at CDC with regard to /SOERPL determinants, in my center, but hopefully give you some understanding of what we're seeing as the external factors that are also influencing this and how that might also contribute to what state, local and tribal territorial health officers might be involved in. So first and foremost, I hopefully do not have to define social determinants for this group. It seems like you're aware, but we consider them to be the conditions in which we work, play, worship and basically do everything else that contribute to our health outcomes. I am sure as you also know, there is lots of data out there that suggests that these various factors are contributing to more than 50 percent of our health outcomes. And in particular, negative outcomes. Next slide. So when we began doing this work, we were thinking a lot about how this fits in to health equity. We really saw this as an element that gets us further towards health equity, that addressing social determinants. I think it is important to remember that we could address social determinants and actually create health inequities. So we have to look through things through a health equity lens. At CDC, this is some of the ways we define it. When every one has hah equal opportunity to be as healthy as they possibly can be. As I said, the social determinant of health being those non medical factors. And I think you have seen this slide before in terms of how the agency is talking about their core objectives. You can see that social determinants fits under this, that umbrella which it facilitates toward the goal. Next one. So when we began this work, we were thinking there was a strong foundation at CDC for work in social determinants. I got here, I had been a health officer in Pennsylvania, lots of people talking about social determinants there. There had been previous efforts, so I came at an opportune time to get additional traction. We have seen things like our work around childhood lead, the reach program, and our center to choose a safe place and early care in education and some of the injury work been done. Some of the home less efforts. We had the social vulnerability, and a recent addition which is the environmental justice index, both of these really tried to address social determinants. And then

in the policy realm, we had the high five work where John was involved historically. As well as all the work around health and all policies and health assessments, health impact assessments going on for a long time. When I personally arrived, I wanted to amplify this in my own center. And we began doing an assessment of what could achieve, been working on. One of the things I wanted express, and that's that there's a difference between addressing or assessing social needs of an individual and talking about social determinants. I think, David, you mentioned this earlier in your conversation. And again, I think this is really important as we understand what is public health's role, and as currently as CMS regulations are changing, I don't know if every one knows, but they put out new regulations. As of 2024, hospitals will be required to do assessments for social needs in number of areas that are of great interest to us, including food insecurity, housing instability, transportation, utilities and interpersonal safety. So this is moving forward quite rapidly as you can imagine. We have done our best to be at the table to ensure that public health has a role to play in the broader community context. Bottom line, if you refer an individual for resources that do not exist in a community, you're going to have a lot of frustration on the part of the individual as well as the provider. I think it is really important to acknowledge that and make sure public health is at the table. Nice picture here building on John's work in the past, where do we fit from public health? And in this river we see ourselves much more upstream of trying to address those social determinants, those causes that range from access to healthy food to addressing structural racism. One of the things we started to say is what are the roles that public health can play. We talk at governmental public health, health departments, but built off of public health 3.0. We talked about public health as a convener, and this came up, I think Josh mentioned earlier in his comments, of pulling together and fostering collaboration, of being able to be a member or leader of multi partnerships. Many of which, by the way in this realm, are publicly available. And measuring what is going on. We're asking local folks to work across sectors. This is happening all over the country, we know that. We're probably late to the game in many place, but the bottom line is in order to do that, we're asking what the health impact changes, perhaps in the environment, might mean to the health of public, and in particular to the populations we're concerned about. But we also think that public health can be a change maker. Sometimes that because of money we're allocates at various levels, sometimes part of the policy making realm, the regulatory realm, that public health often has. But all of these elements together, we think, has really broad and convincing area in which public health can play a critical role. One of the things we have done in the agency is brought together a work group from members of every center. Deb and I are leaders of this group. And we have been meeting, and one of the first things we started to do was think about a frame work. This is an example. We have six pillars, it is fairly intuitive, many will be recognizable just in terms of the essential

public health functions, but we have data and surveillance, evaluation and evidence building, partnerships and collaboration, community engagement, infrastructure, capacity and law. And we now have subcommittees working in each of these areas. So we still have a central goal which is a social determinants of health and social conditions and structural conditions. There has been a lot of discussion on separating those. We really see them as part and parcel to each other. And equity over all as the main focus of the group. Next slide. All right. So we have done a lot of work thus far in this current year. Working on this now at the agency level for about a year. And we do feel that alignment across the agency is really critical and so I will tell you, it has been a very engaging group. People are very enthusiastic about this work. And these are just some of the things that have been accomplished. We have done visual frame work, vetted that with partners. Done a summary of the current work at CDC to understand what is going on. We created a logic model and communication strategy. And the second one with limited practice which was written by a number of us at CDC. There is the logic model. Anyone that wants a copy, I will provide it. People are very interested in making sure this work group is tangible, and that it ultimately has depth and exists in sustainability over time. And so a lot of what we're talking to the subcommittees about is that, what kind of actions do you think need to be taken by the agency, how do they fit within the centers, how do they work with health equity, and more importantly can they be sustained. I did want to give you an example because I know community engagement HAZCOM up a lot. They have been busy. I don't know if any of you remember that principals of community engagement, second edition. I still have mine. Our subcommittee just completed one of the next versions. They also have been involved in thinking about what are the strategies to incentivize talking about community engagement in our notice of funding opportunities. Do we need templates for language, do we need to bring together conferences? I thought what Josh raised is important, because typically CDC is not the action arm of the agency, it is the organizations that are out there in the community. It is the local health departments, it is the state health departments. So how do we incentivize that work, encourage that work. I will tell you many of the NOFOs going out do require, actually, coalitions or relationships with partners. And I think you will see more and more of that as time goes on. Because I think there is a recognition that we need all of these parties at table to really get this kind of work done. In the environmental scan, that really helped us understand what strengths and weaknesses we have in the agency. And I think as noted in the logic model, we have got a fair amount of work to do to get to the long term outcomes that we're interested in. Next slide. There you go. The whole government approach. Next. And next. I will give you an idea of the more granular work going on. One of the things that happened, is we needed to identify a group of social determinants that we thought we could get our arms around. Social determinants is big. We also wanted this to really echo some of the work going on, play to our strengths so to speak, and also speak to things

that we believed influenced the outcomes in chronic. We identified these. Food and nutrition insecurity, I'm sure you know there was a large nutrition summit held several weeks ago by the White House. Tobacco free policies, we have been in that environment for a long time. The built in environment, which certainly can include transportation and housing, but as things like economic development, how buildings are literally set within an environment and certainly new construction. We have added community intersectedness, which involved the elderly in the community, it is challenging and rapidly as things are changing in the health care system. In order to address these, we have focused on groups focusing on measures and really how our NOFOs, we have many going out this year, trying to imbed these constructs within these NOFOs as well. You may have heard, we got our first line budget about two years ago. Thanks to many of our advocates, who were really interested in this, there were 7 counties, one tribe, two city counties, and three cities. The language we had allowed us to only fund state, local and tribal. This is where that question about community organizations, the appropriations did not allow us to open it up to larger groups. I will say this was very frustrating for us as well as communities because a lot of work going on around this planning process is not necessarily coming out of governmental public health. It is coming out of organizations that may engage public health, but are being lead by a whole variety of orgizations. I did want to highlight one, because this was a grant, and we're now getting the plans in. They're coming in now because they were due to come in end of September, beginning of October. St. Louis county, Florida, they have a health system, and the lake superior community health center as formal partners. They focused on community linkages, connectedness and food security. In addition, there were others in Duluth where we saw local organizations working together to do their chip and /KHAU, which is really fantastic. They are planning together. We have seen a lot activity and have just funded new grantees. One of the things we felt early on is we weren't getting enough practice based evidence on the table to really understand what made these coalitions tick, how they could do their work. So we began an initiative with both S-T-O and N-H-O getting further faster. In the first year, we asked them to identify social, and they identified 14. And we have had the luxury of a rapid evaluation, so already an evaluation report, those in production and products, and we are learning a tremendous amount about what is going on. 90 percent had community changes they were proud of, but we also heard from most of them, that they still needed help in sustainability and funding. So what else is new? We knew that was part of the challenges. Monica, I think you mentioned it earlier when you spoke of the infrastructure dollars needed to keep coalitions moving and active and engaged. In the second year, we have 14 communities where we're really digging deeper and in particular we're asking them to pilot measures to see if they're feasible, if they can get the data, what they think will be helpful or not. And we're also starting to look now at the relationship between health system and public health. And in the third year, that's what we will be doing, trying to identify some of the successful

partnerships across the country. And we're working very much in partnership with CMS in that year three. I also want to mention another project that we have been involved in. Next slide. This is around the data issues. I know something came up around the behavioral risk factor surveillance system. But we also did something with the gravity project. One of the questions coming up, is the data the health care system will be collecting, will it be valuable? And this project with gravity, which was quite a large project involving a wide ranging coalition of folks from multiple sectors, basically identified that it could be extremely helpful. I think the challenge continues to be can people get access to this data? The two elements will likely be the screen itself, however that is inputted in to the electronic record, but also something called Z codes which people may not be familiar with. And I think with CMS is now trying to get a lot of public documentation on how that may be used in the future. So a lot about this interoperability that will be really important. Something came up earlier, next slide. So places and behavior risk systems, we can talk about that later and answer questions. But one of the things that happened with the Robert Johnson foundation is we were able to take the risk factor data, and through small area analysis make it available and granular levels. So literally you can look at it at the census level. You can see between one neighborhood and another. Now, it does not remediate any of the challenges we have, but as you probably know for many jurisdictions, this is the only chronic surveillance system they have. And it is free, which is also critically important for many jurisdictions. One of the things we did in the last several years is we have added a social determinants of health module. We were able to support 42 states, remember, this is completely voluntary on whether these states want to use it or not. But 42 basically said yes. And we have also been able to fund them for a second year. We also have a racism module, I don't remember – I think it is 22 states that said they would as well. But one thing in the module that are not in the core group of modules, is completely up to states as to whether they want to field them or not. But I think this is exciting, we hope to have first information on this. And at the small area analysis by next summer. Next slide. The other thing I wanted to mention is we have been involved at multiple levels with HHS. And with the whole of government approach. I just wanted to talk to you a little bit about some of the things going on, because these greatly influence where we are at CDC, how we see ourselves within all of the movement that is going on around social determinants. And we are always looking to expand. So HHS had an advisory committee and developed a plan. We were very much front and center. In addition, the White House has also done an IP C in which they are currently doing a social determinant of health plan, which I am supposed to turn in today by the way, with some edits. But the good news for us is that we are being asked every step of the way to engage, comment, and our edits are being taken seriously. For example they changed social determinants to health needs. We have been working with CMS around the project and that has been successful for us in terms of understanding where they're coming from and what they need as well as how we think they could potentially use their levers

as well. Now we are engaged with ACL, which is focused usually on aging but also interested in what is happening between human service organizations or community based organizations on the health care system, and they believe these referrals are going to come fast and heavy. And that many of the community organizations may not have the infrastructure or capacity to be able to receive and then refer appropriately. So they have been talking about a community hub in which data would be shared or there would be a unified group of human services that would be able to manage contracting, issues that may come up. You may get money and reimbursement, and then you have to figure how to manage that. We want to make sure public health is at the table, not left out of this discussion. So we have contributed through an I AA 2 work and hopefully later this year, I know they have 65 interested groups and we hope later this year they will be able to issue their NOFO and we will be part of that as well. You probably know that in the knew which you are and only time will tell, there /HR-FS additional resources put in the house, senate and president's budget last year and also this current year. And last year, we did not get those resources, as you probably know, there were other priorities. This year they're back that would allow us to do implementation as well as additional research in the social determinant of health realm. So we have been planning for that, but our intention is to keep moving with this work regardless of whether those resources appear or not. So we think there has been some great wins so far. Our center has emerged as a champion, we're proud of that. It is a real pleasure to be involved in these meetings. People have a lot of innovative ideas and are very committed to moving this work forward. I think there is a lot on the horizon as the health care system getting involved in social needs, social determinants, however it is being framed. And I feel we need to be clear we are part of this discussion, we can help to amplify what is going on in the health care system, but that we cannot expect the health care system to do this on their own. With that, I will open up for questions. >> Thank you. Karen, I have heard you speak to this plenty of times. To see the energy and wisdom you're bringing to CDC, it is great. Let's open it up for questions, discussions, suggestions. We do think this is an issue that is critically important to think about as we're making recommendations on health equity. As you said, the over lap between the two is important. Any comments from the group? >> I will ask one while people are thinking. It goes back to the data issue. This is reflecting for me a little back on my days as being a local health officer. Recognizing a risk factor system was great, but it essentially was collecting information on individuals in a community. So when you think what can we do, and what are the community drivers of health, it was less useful. I am wondering have you been able to do any thinking or generate ideas around what a core set of community level of measures of health equity might be, and any progress or advice you could use from us in moving that forward? I am talking about simple things like presence of safe roots to school in a neighborhood, green spaces, or even reflecting on my Seattle experience, the location of social services which is a big problem in Seattle, all the social service agencies was in a place

where Seattle cities were needed and then poverty moved to the suburbs. So there was a disconnect between where the people that needed the services and where the services were located. That kind of thing I think would, to the extent there was some consensus on what people may look at might be helpful. >> The first one I want to mention, I hope I am correct on this, is we're looking to incorporate the environmental justice out of the national center for environmental health to the current places and behavioral risk factors. So if you look, it is both. Sort of how do we incorporate, because I think my gut would tell me as a previous recovering health officer, that you kind of want a one-stop shop. So I think the interest in trying to figure that out, we are also involved now in another Robert wood Johnson program coming through the program where they're actually talking to local groups to try to determine what data they want to see. My hope is that will influence what we bring. Now, there are a lot of challenges. It is self reported data, still random telephone, digit DIAL. It is hard to get responses. But we have at least made it accessible to folks. Anybody can look at the website and look at their community and see some of those things. So I think it has enormous potential. We have also been conducting webinars for state and local about how they can import data that might be important to them. Because I will say the places data does not have the full spectrum of every question, I think it is like 27 of the variables. Making sure that the capacity is there so they can combine that data. There may be something you want to grab at the local data that is not something we would have access to. And you should be able to put them together, you know, crime data for example or opioid, emergency room data. We're trying to address from the technical assistance side as well as getting a handle on what is it people want to see in that package. >> Thank you. And please let us know if there are any recommendations from a committee like this that might help you in your efforts to accelerate progress. >> Josh: Thank you. This is fantastic to see CDC so involved. I wanted to ask you about workforce and the intersection between social determinants of health and workforce. One thing that we have tried to do is give scholarships to people in other fields to kind of give them public health tools to help address some of the data needs but also policy and community engagement, sort of use the public health tool box in education, housing, policing, in other fields. That is another way public health can be useful to improve the social determinants of health, to not -- I mean, complimentary to everything. Has CDC thought about that? Ways that CDC could be training people from other fields or putting materials together for people from other fields, not just the public health side or health care side of the social determinants of health discussion. >> That is a great idea. I don't know that we have looked at it specifically. I do know that in the opportunities that states are having with the workforce dollars with the new infrastructure, they can choose to do something along those lines. And we did work to create, along with John, some job descriptions essentially for works to do the things you're talking about. But whether or not states decide where to

spend their resources is ultimately up to them. It would be interesting to see, in the reach program, for example, how much of those resources are going to non health related groups in terms of working together. I think that might be an interesting exercise to figure that out. Great idea. >> Thank you for walking us through that. I think you added more to the slide deck since you first shared some updates with us on. Two questions. We were on a call last week with colleagues from HUD and it was related to work around health equity and housing. We started talk about other social determinants of health. And they describe some of the conversations around data use agreements and the complexities. You were referencing work with HHS, but I was curious if you could say more about other agencies. The second question is I know you were focused on B-R-S-S, but if you had similar updates to share with work around Y-R BS. >> I will say, Y-R BS is not in my center anymore so I don't know much about the specific details. I have heard there are some concerns about whether all states will continue to do the work. That's about all I can say. The other question about other organizations. So there are been activities, and I am sitting next to the person at the leading edge of that work with HUD, FDA, and transportation. I have been lucky enough to get invited. I would say HUD very enthusiastic on trying to figure how to weave that in the work. We do have a history of smoke-free housing which is important, and the environmental health work around asthma. That is a little different with the home less issue, obviously, which is more about homes, period, and having housing. There is a lot of potential. I also wanted to mention with transportation, they did receive a fairly large amount of money through the infrastructure grant. They do seem interested in health. One of the challenges is that the coalitions around transportation are their own group of people. So when those new grants come out, those new resources, public health is not always at the table. So we're trying to encourage them to be there and be involved in the planning of those grants, because that's really where the opportunities will be. But I am going to pass it over to you, John. >> Thank you. I would give a couple of examples. Within the social determinants of health task force that Karen was describing at CDC, there are different work groups or subcommittees. One is a partnership subcommittee, and it has decided to do in its preliminary work, pay special attention to housing. For example, at the last partnership meeting, HUD senior leadership and senior leadership working on housing from the state came to the meeting and talked about who are those partners. If public health is really thinking about working with the housing sector, who do we work with? It is at the state level, HUD level, local level; what are the different organizations so there was a better understanding at CDC about the complexity of working in partnership. So as we're working with our state and local, tribal, territorial partners, we can learn from them, ask them the questions, but make them aware of what we have learned about those partnerships. And there were a variety of other approaches. We approach the Department of Transportation in particular in mind with the

fact that the infrastructure act that passed this year gave them a half trillion dollars worth of new resources. And that many of the projects they would be supporting had a public health impact. Whether it is highways, mass transportation, or walk /-BL communities. And we have been working with the Department of Transportation by having Celeste fill lip, a deputy director at CDC, play a role in their strategic planning process. She along with Dr. Walensky just presented earlier this week at the Department of Transportation strategic planning analysis to talk through the relationship of public health, transportation and other sectors. So we're really trying to get to the weeds more and thinking, you know, what do we have to do to have meaningful relationships and not just talk generally on working across sectors. >> Thank you for sharing more details. I think we look at work with HUD, and this is some what related to what Rachel brought up, in looking at other indicators. Definitely with the evictions on the up tick, I would imagine there is a role for CDC in terms of what happens as a result of some of those protections being lifted. And then on the Y-R BS, I did hear through the grapevine that their schools dropped funding and support of rolling out. I know it was voluntary, but that is deeply disturbing given what we are hearing about in terms of youth mental health. And then on the tobacco control front. We relied in terms of the effectiveness of our tobacco control regulations. I didn't realize that it was no longer in your control, and I am aware of that. >> We don't generally use Y-R BS to assess tobacco use in kids, we use the N-Y-T-S and that is on track. I think the data came out last week talking about the recent data there. So there are challenges with almost all of the surveillance systems using different methodology prepandemic, and then it had to transition to a different type of methodology who does it virtually, doing different challenges. One of the concerns we have is can we compare the methodology now to the methodology prepandemic to assess changes over time. >> Julie: Thank you for your report, Karen. I am sitting here, thinking about sustainability of your work. I think you have done a lot of work with very little budget and not a continuous stream of funding. What are you thinking about in terms of how to advocate for or leverage additional funding. And what came to mind was whether because there is such a strong connection between structural barriers in the upstream systems, and health inequities and racial disparities, is there value in your working together with the health equity unit or office to try to get some dedicated and allocated resources moving forward? I worry that it is hard for you to garner the kind of support you need to keep this work going. So I wonder what you're thinking. >> I think you're right. We all I think in this business look for the opportunities. And when the opportunities are open, we want to take advantage of them but we also recognize that the pendulum swings and there are changes that could potentially go on. From my personal perspective -- first, I think we work with the health equity group substantially in terms of what is going on. I think as the new office emerges, we need to do more than that. And /PERBLSly when I was talking earlier about where did some of these things end up resting, end up sitting. Like any other coalition,

we probably can't keep a coalition together for ever, right? There has to be some sense of what we achieve and then how does it get to be part of the organization. My hope, at least obviously I can only speak for my own center, but I am doing everything I can to imbed social indeterminants in to the work we're doing. You know more than I on the community transformation grants and that legacy. I am hopeful we could get implementation dollars and sink our teeth in this. I think we do need more -- the community guide is helpful, but we need more evidence to be able to actually support the community guide to do the work it does. So my feeling is that part of this is, and maybe because I was with the director, but maybe you Don't need that much money, you just move forward. Sometimes you get the most success and sustainability when there wasn't a huge amount of resources. But with that said, I think our communities are very interested in this, you all are very interested in this. I think our various partner organize visions are very interested in this. And so -- and I do believe, Julie, because of what is going on, there is a legacy there. So the challenge will be, does the health care system basically just take the ball and run with it? And public health says we have other business to do, which could happen. That's happened. We all live through the triple lane. So there is a challenge in understanding what the impact will be, and hopefully we will see health departments recognize that they need to be part of those conversations. That is a concern of mine. If people are exhausted, they have so much on their plates. And do they see this as being something they need to be aware of. One of the thing I will say as a recovering health department director, to a certain extent there is a possibility you could end up with multiple coalitions doing some of the same things in the community. And I don't think that would be helpful. I think what we're trying to do is figure out how to make sure those things are connected to one another. I think partnership with the other organizations, whether inside HHS or outside HHS, is one strategy for trying to make sure that doesn't happen. >> Thank you, Karen. Great to have you here. We look forward to working with you on this. We're on a break. The break was supposed to be for 15 minutes, so can we split the difference and start at 40 past the hour. >> Whereupon a break was taken for ten minutes. >> We will reconvene at 20 till. >> Back from break. >> We are delighted to have this last presentation, and I would like to thank Kevin for coming. He is the director for communications and the most senior official. He in the past has been the assistant president of HHS and he will be talking with us today about CDC's communication office. I have already warned him that his ears should be burning because there are a number of questions on this. We look forward to the discussion. >> Thank you. I will apologize, I am a little under the weather which is kind of the by product. My steady state of having two young children, I have my personal super spreaders that live in my house. I want to talk about the reorganization of O AD C. This was a process that started years ago, started on the foundation a few years ago. The reorganization was just completed this August, and it really is connected to a lot of the priorities that were outlined in Jim's report

and were ultimately responsive to that. And then I think anticipates in a lot of the ways the challenges identified and then the potential solutions. While this did start well before moving forward, it does reflect a lot of the concern that Dr. Walensky has about communications at large within CDC. And it really was a part of our charge to address that. On the screen there you see a little about the background and how this process began. I do want to talk about the work that went in to it; as Abigail is here, she was the acting associate director for communications. They held internal O AD C, individual interviews with people across the organization. They talked to communicators from all the various centers in how they work with O AD C and what they thought were issues they could address during the course of the reorganization. And really did a thorough review of the state and its functions in how we could improve communications. Next slide. I did want to mention not only Abigail but Kate, they were all dynamic people and huge assets. Without them this process would not have moved forward. As far as the priorities, you can see and probably guess how a lot of them might interact with or see the recommendations made by Jim streamlining functions in services, retooling symptoms to be more focused on function. In simple language, two of the primary problems the team was trying to solve for reflect some of the consensus for change that Jim covered in his process of the review of the functions of CDC during the COVID response. The need to better communicate with the public both through media and direct communications. So the former structure here, and it may not jump out on the page, but I will point out a couple of issues you can see from the structure that may have caused a problem. We have the news media branch, the folks really responsible for interacting with the media on a day-to-day basis. And they're buried down in the second layer under the division of public affairs. And the same thing for the digital media branch. Ultimately, I think that the structure is a reflection of values and what O AD C's structure indicated was that our work with the media and communications with the public through digital platforms were not paramount importance. So what the team did was try and address that. Next slide. Here you see the new structure, elevating the media to their own divisions. That has important implications because we're able to have direct conversations on a daily basis and talk about the work happening. We have been talking with the White House about Ebola, and help the public better understand what we're doing in Uganda and the US to better prepare in case there is a case here in the United States. So it is simple as me picking up the phone and talking through that with the head of our digital team, and how we might -- so different stratifies for getting that information out. And by midday, we have a communications that have gone out to the public via CDC.government, walking through all the different things we're doing, working with the ministry of health in Uganda and some of the things in the US as well. I also do want to point out the division of science and services, which is one of the divisions there to promote and support scientific practice of health communication and evidence based knowledge to health practitioners. The important thing they're working on is how do we

communicate in plain language. They are at the forefront of that work around also work around audience research to figure out the best way to talk to the public in language they can understand. Next slide. So I will talk a little bit about what all of this is meant to O AD C and communication more broadly. Elevating the teams based on functions, streamlining and prioritizing functions and services. Again, going back to one of the priorities being able to cultivate a more collaborative cross functional culture so that we're thinking about communications in a wholistic way. So when we're putting together roll out packages for an announcement, the digital team is talking with the relations team, so they're all complimentary of one another. And then putting an emphasis on internal and enterprise communication. The internal is housed within my office, and a lot of the work they're doing, whether it is around the initiatives that are science based or even moving forward, really has been instrumental in helping the workforce better understand the science behind some of the decisions and also the rationale behind some of the work we're doing related to moving forward. Now we are pairing the work done with the reorganize through additional improvements that have been identified by communication sprint teams that were set up during the initial announcement of the moving forward initiative. Those sprint teams communicated across all, ultimately touching one in four to get feedback on a variety of different initiatives. Through that, they were able to identify a series of recommendations. And now through the priority action teams we are working on a path we for implementing those recommendations. I will talk through these briefly and then we will answer questions. But working on the digital modernization, this is work that Carol began and has been working on for sometime but really moving forward it gives us an opportunity to accelerate that work. Trying to look at metrics, audience size, usability, purpose of content and how it is to be formatted. Making sure there is a clear policy for ultimately what goes on CDC.government. Thinking first about how the American public will access that information, and making that the paramount concern for us as opposed to being a place where different centers might be communicating with a more insular audience or themselves. Really looking at standardizing the roll out process across the agency and creating a roll out plan. Often times it involved one team not having visibility about what another team is doing. By standardizing the roll out process, we are directly addressing that concern and improve visibility across the organization. And then also working to develop an editorial calendar, essentially, of information going out of this building and going on the web for the entirety of CDC so that everybody has visibility in to and can better align activities. Also trying to look at to improve our communicators. Looking at training to make sure they're up to date observe the media landscape. It has changed obviously rapidly during the last five or six years, even, and certainly that change was accelerated during the course of COVID pandemic. Again, we're continuing to see a much more diffuse media landscape which just presents a lot of challenges for getting information to the public. Ensuring that we have web strategy training for our communicators so they have a basic facility with that information. And requiring some training

for our leaders, branch chiefs, on communication functions and helping to ensure they know about the communication expertise that resides within O AD C. And their own centers. We have heard from staff that there are different places where communicators are seen more as a service function and not strategic partner. Our goal here is to ensure that everybody knows they can count on them and ensure they're at the table when decisions are being made so that considerations on how audiences and the public might interpret information being put forward, so they can actually be a part of that process and ensure the audience and the public is in the front of people's minds. And then of course looking at emergency response. This was one of the big areas identified in the Mc/KRAEU report. There are a variety of different issues we're looking at related to emergency response, and I think ensuring that we are structured the best we can be so that my office is able to communicate with the joint information center and the response so we're better able to help the communicators in this place understand the different externalities that we may be aware of and that they may not be aware of that can cause situations to arise where people can be at the White House or HHS or anywhere else within the media with different information being disseminated. So it is really a process of helping improve visual awareness and sensitivity to different issues that may exist. And trying to figure out how to do that by addressing some of the structure of the response. Next slide. Well, that's it. So I'm happy to answer questions. I was on my way in here and Jim said there were a number of them. He also said he answered most of them, but I will take whatever he did not get to. >> Floor is open. >> Thank you for that presentation. I hope you feel better and the kids feel better. I understand the reorganization you're doing, but you didn't tell us how it will make it better. The scientists want granularity and data, the non scientists want understand /-BLT. This is intrusive, but how is that reorganization going to give that result? >> Again, I think it goes back to the communication science division, elevating that as its own division and they're working on a number of different strategies to help infuse plain language across the organizations. How do we give people, and this is part of the moving process and the priority action teams working on this, how do we give all of the divisions and centers across CDC the tools necessary to be able to take complicated science that is nuanced and explain it in a way that everybody can understand. There are tools that exist that can help with that to ensure that you are communicating in a level that every day people can understand. So I think by explaining the science communication division, elevating the importance and then also giving the folks there this charge, I think that is one of the ways that we can address the challenge you're talking about and the way the reorganize deals with that head on. But also to some degree it is matter of people like me making sure that we are constantly reiterating the importance of that and sensitizing all of the leadership, the communication leadership across the organization. >> Do you test your messaging out on scientists? Do you test your messaging out on the public so you know you're reaching the right level? >> Yes. I mean, we have the ability

to test information with the public and we do. And we also have a reservoir of publicly available data we're looking at all the time to see how the public responds to various issues. I do think that -- I feel confident in terms of speaking with other scientists, that our experts have a great facility with that and I guess I worry less about that than making sure that we're able to provide information about complicated issues in a way so that people can take action on them. >> Can I differentiate between the website, which I think is pretty good really, I use the website, I don't think it is the information on that that is the issue. It is the emergency, what do I do now? And that's the the area, to me, that need it is focus and the testing, the experimentation? >> We do have the ability to do that in real time and we will continue to do that. Again, some of this does get back to the structure with the joint information center and the response to that we're making sure that we are communicating across those two organizations about the importance of communicating with the public and making sure we're set. That we have jointly agreed upon the messages we're going to be using. Because I think in certain points, and again today the my time here, but obviously I use news as a consumer to the CDC, there may have been messages decided upon jointly with CDC, HSS and the White House and that information was not communicated well enough across the organization. >> Can I make one more point and then I will be quiet. When you're giving information in an emergency, can you say this is what we know now? I don't think that most people are not in the field, not in science understand that it evolves day by day, I don't think they know that. And if you can say this is what we know now, tomorrow we may have more knowledge. But I think that's an important message for everybody to hear. >> Yes, I agree with you completely. I think that was one thing Dr. Walensky was focused on during the monkey pox. There was a TV critic that was making a bad faith argument about one of the issues she brought up, but in the clip that was played about the issue, she indicates this is what we know right now. But I do think we could do a better job explaining to the public that the information could evolve, if it does we will tell you. And just be forward about that. >> Thank you. >> So we have a number of comments and we will do Josh, /OBG /TA*EUF I can't, Monica, Lynn and Julie. >> Thank you for your presentation. I think you talked about, getting parts of CDC to talk to each other, getting the message clear to people, those are really core traditional public health communication issues. You are trying to get better. To my ears, what you talked about was applicable ten years ago, it is important today, important to do, but I didn't hear how it takes in to account the totally information environment that CDC is in now. Where a message is just the very, very beginning of communication. I teach a class on misinformation and we have people who study misinformation come and pat me on the head in one of the classes and say you're such a naive public health person. You think if you just test the message, get it perfect and serve it beautifully, people will hear it? They're getting tons of misinformation, a thousand to one. That's the environment we're in today that wasn't in the environment or challenge ten years ago. And I will give you another example. In one of

the classes, we had the students look at the issue of my owe car /TKAOEUTS in MRNA vaccines which is a complicated issued. We asked them to find TicTok videos responsible and those that were irresponsible. So we need to picture a class of 40 students and we watching the best ones they could find. And as soon as they started, people are talking about data and numbers and papers, and my own students are looking at their e-mail in class. They can't even watch the end of the TicTok in some cases. And then the group doing the irresponsible TicTok video starts and you have nurses saying there's a cover up about patients and they're crying. And they have tons more hits. So much more exposure online. And my own students are riveted by the TicToks. There is no question it is much more appealing. That is the world we're in now, this thousand to one information. We can do as many focus groups as we want on getting the message right, but that's only now the very beginning of the challenge. Where is misinformation on your organizational chart? Where is the response that's necessary to address this completely different world that the public health is in right now? >> The misinformation/disinformation is in the communication science division, and that is something they're working on. I will not suggest that CDC can solve this problem alone. And government agencies alone will not solve the problem, this is something we are going to have to work on constantly. This is a problem much larger than government, than the private sector. >> How does that affect your job? I understand of course it is larger than CDC, but how do you envision CDC engaging? >> It is a variety of different things. It is the importance of continuing to use every channel we have available to get the information out. To not rely solely on government channels. I think during the course of the monkey pox response, the outside world may not have been aware of it, but we really did a lot of work with trusted messengers for the LGBTQ community to get the information out about how people could protect themselves during the outbreak. Now, that is not something CDC looked to take credit for or we were out front in public about, but it was work that was done quitely through people we had relationships with. I think that is one of the answers, is working through folks who are working in various communities and trusted to get the information out. >> I appreciate that. I will give you three quick ideas. Every communication plan that comes out of CDC should have a misinformation component. Every roll out plan. You just missed two days on what misinformation comes out and you're so far behind. You can have an advisory commission on misinformation. This is a multi disciplinary problem, and nobody has the answers. But /T-GS an enormous threat to public health. I wrote the third one and I can't read my own handwriting. I do think this is something that will just be so important for CDC. As you think about the challenges and the reorganization that you're doing, how that will play out in this and how CDC can inspire other people to address it, will be incredibly important. Thank you. >> I don't disagree with you. I am open to obviously ideas and it is something we take very seriously and are thinking about. As an aside, interestingly, TicTok has one of the stricter content moderation policies of all of the social media platforms.

>> That was the third one, engage with social media companies. That is important to do. >> Thank you. In the same vain, thank you for your presentation. As you can see it is really critical topic for CDC and it has gone through the ringer as we know. Thinking outside the usual channels and the future, and I love your plain language of communication science approach which I agree with. But having been on the presidential COVID-19 health equity task force, one of the things we heard a great deal about from the entire country is how our youth and teenagers felt forgotten about for anyone providing information to them. It was all the science, the adults, but teenagers and youth, young adults, they weren't hearing it because it didn't seem to be directed toward them. So within that context; just thinking with you and throwing out about outside the usual channels, have you been thinking about how to communicate with our youth as an example, communication is needed for high schoolers and middle schoolers, many of them have radio stations and newspapers of their own. I am thinking about talking about misinformation and all possibility of enhancing public concepts and infusing that maybe very special TSAs to that population group. I wanted to know what your thoughts are, and maybe how to get to a younger group when we talk about such important issues. >> I think foundational is what is your audience. And if part of the audience is younger people, what are our avenues to be able to reach them? Obviously social media is important. I do also think we would come back to looking at different people who might be influential in these communities, folks that young people look to for information. And information and entertainment frankly. And I do think that audience segmentation is a key part of the work we would do, and it is foundational to every communication man one would build. And I think also looking at how do we ensure we're doing the message texting to make sure we have age diversity in the groups we're testing with so that we know if there are messages that work better with younger people and that we're doing it in a targeted way. I think that something that during the younger men during the monkey pox response, working with the data apps to get information out specific to how people can protect /TH*ELS so it is not guilty something we're thinking about, and I like I said foundational to our communications planning. >> Good to hear. One thing earlier when talking to Josh was talking about trusted voices. The concept we're on board with and I totally get that, however the caveat is those that are listening to misinformation, they see them as their trusted voice and not the CDC. And how do we also ensure that we are taking that in to consideration and become the trusted voice once again. Not that I expect an answer, but that was just on my mind of which is – because we talk about trusted voices, but it has also become quite clear in Texas that the trusted voice is not the one you and I would probably decide is the trusted voice to be listened to. >> I think others have already lifted up some of the questions that I was going to raise, but I mean just to go off of what /OBG /TA*EUF I can't said, definitely microinfluences depending on whatever neighborhood or context people are. And just to go back,

in the absence of information, say, during the pandemic, different groups were stood up so we are part of the collaborative, we have crafted in time, easy to understand, communication tidbits for practitioners. Some of the challenges is about this issue of trust that /OBG /TA*EUF I can't has raised. Since we spoke this morning about moving forward, that could be an opportunity in terms of developing new narratives about who CDC is, what you all do to rebuild trust. I appreciate, having served in a city and health department, I appreciate the need to get the house in order first and getting the organizational struck right. But wondering how you are thinking of moving forward not just as an exercise of rebuilding or restructuring, but rebuilding that trust. I was wondering if you could say more about that. >> Yes. I think one of the keys is to make sure we don't have any errors. So a lot of work we're doing around communications involves ways to make sure we -- you know, no organization will be error free all the time, but to ensure we're doing everything we can to eliminate mistakes. That is obviously helpful to the over all restoration of credibility for people who have lost some faith in CDC. I think moving forward, a number of different issues that have been discussed from aligning the work, all of that, is ultimately I think in the service of improving how CDC functions which ultimately feeds in to improving trusted organization. But it won't happen unless we talk about it and help connect the dots for people in terms of what specific changes were made and how that will ultimately help us function better in the future and also provide examples of how changes that have already been made is improving our work on a day-to-day basis. So it is up to us the make that case publicly. And obviously, we would look to every one in this room to be able to help amplify those messages and explain to people the work we're doing. >> Yes, I want to thank you for being here. My communication to folks is if you're sick, don't come to work, but I guess CDC does not give that advice. A couple of things around my mind. One is that I think the public is not convinced that CDC is doing it job even when it does. For example, later on in this meeting we will have a presentation about monkey pox, which is a really good story in terms of the response and how quickly the rates have come down. And that is not the story the public is doing. I know that is not your job to /TOUT, but for those that care about public, it is bad when the public doesn't think that the CDC or public health system is protecting it. It provides credibility for those piling on misinformation. It is not about /TKPWHROR fieing the director or the agency, but that the advice is sound advice. I know you did a great job in reaching out to the community and others I saw how the strategy worked, but that is not -- the story that the people had is once again, you know, CDC didn't have the information, CDC wasn't there. And it is so wrong, but I really think that is really important aspect. I also think there is a perception, right or wrong, from the past, from the last administration, that there are watchers over the agency that are editing things, changing things, that the politicians are messing with the data and messing with the communication. And whatever can be done to restore the confidence and the scientific integrity of the agency, the public again feels they can be secure. And what they're hearing from

CDC is based on public health principals and science and not politics. It is hard to get rid of that stain after it occurred. I was at the EPA at the early part of the Clinton administration when we had that problem, multiple years where there was interference of the work and the agency. It is very hard to get past that. One thing I was confused on is what is the communication enterprise in CDC? It sounds like you have communicators throughout the agency, and I hope your job is about bringing forth the communications and less about controlling them, trying to say that nicely. I mean, there is so much that needs to come through. But unlike what some others have said, I did see during COVID a lot of inconsistencies in the communication. We were trying to understand what is the CDC policy, because we're sending policies to our campus, advising local government. We're trying to figure out, what is the CDC recommending how to isolate or ventilation? And we were seeing different things. I think what you are doing to try to establish more con sis ten /SEU is important. Because there were times it wasn't clear, I know because the science wasn't clear, but still it is important because the message needed to be simpler from the CDC and you couldn't see on this page it says to do that, and on this it says to do something else. That was not helpful. >> I mean, in terms of the overall structure, the best way to think about it is O AD C is the communication function of the director. The centers and divisions also have communication functions. It is decentralized function. We are trying to do more in terms of centralization to help improve visibility and provide additional leadership. One thing about monkey pox, this is an on going conversation we're having with reporters. My point is if success has a thousand father, surely we are one of them. We talk about that. Shots did not get in to arms by magic. So that was a lot of work done by CDC. I think one thing that has changed about the media environment over all is reporters can know in real time and editors, how the public interacts with their story. Now that there is less conflict, and it is more about how to we see this moving forward and projecting that there is less interest in writing on it. And so our job and the folks on my team talking with reporters every day and making the case that this is something that we need to talk about because CDC and our partnership across the government did a good job here. And frankly the progress we made from the newest case to now is remarkable. >> The lesson from that, what I learned is the story has to be good right out of the box. Once it is negative, that is the story. You can't change reporters facts on what is the story. And it is true, they get more attention for a negative story, those of us who use Twitter, if you have ever done a negative tweet, you get a lot more re-tweets from a negative. But it is right from the beginning. And that didn't happen. >> Thank you for staying are us. Last question? >> So thank you for your work. I think it is clear you're putting a lot of work in to this and building a structure to help improve communication to the public. What I thought was having been a beneficiary of CDC communication for many years at local public health was if anything the CDC in the area was stronger in provider information on what to do. Now there is a desire to really –

the pendulum should swing more to strengthen the work that you do with the public. I am a little concerned about is over correcting. You lose sight of the other audiences. In addition to the public, which is maybe bigger than you all recognized in the past, you still have academic institutions, scientist, public health, state and local, those who are really dependent on the information that needs to come. I have poured CDC website during many public health emergencies and been able to find what I need and I know how to navigate the site. I would hate for a time to come when there is so much information to the general public that practitioners on the ground or state or local level can't find what think need. So just cautioning on the balance. You don't want to over correct too much. >> Yes, it goes back to one of the issues that Josh raised. If we can't combat misinformation, is everybody isn't on the same page about what the facts are and providing the same message out at the federal, state and local level, that work is critical. One of the issues identified during the process of doing this evaluation of how the COVID communications occurred, was the need to make sure we have a one-stop shop for organizations so they know where to go when they need information, and that we're communicating consistently with them. That was communicated, and I have reached out to the leaders of the main public health organizations, so they know who I am, they come with me, and that we're concerned about this issue and we want to make sure they have a consistent point of contact and they have heard our feedback. >> Thank you so much for spending your time with us. I think there was a lot of interest, wisdom and passion in the room on this topic. >> Thank you so much. Take care everybody. >> So we're approaching the end of the day. As you know in our meetings, there is an opportunity for public comment. And we have decided to go ahead and have that opportunity today. So we had one individual, I am hoping she is on the line, who wanted to make a comment. It is Kristy, the head of the big city health coalition. Without any further adieu, if you can hear me. >> Thank you. I run the big city's health coalition, we have 35 members from the nation's largest metropolitan health departments who together serve more than 61 million people. So I want to thank the ACD for all the hard work you have done. We are so pleased the committee has been reconstituted and look forward to having current practitioners to the mix /-F Over the the last few years we have had multiple health crisis from opioids to gun violence, COVID, monkey pox, and it illustrated just how emergent challenges almost always hit cities first, and often hit them hardest. Many of the things that make cities great also make them uniquely vulnerable. Our member jurisdictions live in close proximity, structural problems. But cities offer also opportunity to take on these challenges and as so many of you know, our members really are at the forefront of doing that. So again, we appreciate the work the ACD has done, in particular the two working groups on data modernization. For example, we're exploring with members how best to move from declaring racism as a public health crisis to actually rebuilding systems, policies and practices so that they mitigate rather than exacerbate racism. Data modernization is also critical. We can't move the field forward if we don't address

data gaps of all levels of government. And federal data modernization dollars must get local with really important guidance from the CDC around data systems and data collection. We cannot have a fully integrated health system without building capacity at every level of government. Finally, neither our members or CDC can do their work without effective partnership. I would be remised not to recognize the role that C still has played for health departments across the country, particularly during the COVID pandemic. This has been a resource for practitioners and as new mechanisms are spoke of, we must preserve that function. Again, thank you for the work you're doing. We look forward to engaging more and thank you for giving me sometime today to comment. >> Thank you. It is great to hear you speak and we appreciate your insights, your work and the work of the big city health coalition. >> Thank you. With that, we're done for the day. Thank you very much to the committee. We have done a lot of work today. We have a dinner this evening at 6, p.m.. it is in the peach tree creek room. See you all at 6, and then tomorrow we start at 9 a.m. and we will be out no later than noon so hopefully people's travels plan match with that. Thank you. >>