



Minutes from the
January 23, 2013

CDC Advisory Committee
to the Director
Health Disparities
Subcommittee

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Advisory Committee to the Director Health Disparities Subcommittee: Record of the January 23, 2013 Meeting

The Centers for Disease Control and Prevention (CDC) convened a meeting of the Health Disparities Subcommittee (HDS) of its Advisory Committee to the Director (ACD) on January 23, 2013. Participants attended in-person at CDC's Clifton / Roybal Campus in Atlanta, Georgia and by teleconference.

Introductions, Roll Call, Welcome and Overview of Meeting

Dr. Lynne Richardson, ACD Chair and Designated Federal Officer (DFO), called the meeting of the CDC HDS of the ACD to order on Thursday, January 23, 2013.

Ms. Gayle Hickman called roll and established that a quorum of HDS members was present either in person or via teleconference and video conference.

Discussion of Recommendations to CDC on Health Disparities / Health Equity

Dr. Will Ross reviewed the January 18, 2013 version of the committee recommendations prepared by himself and Drs. Bonnie Duran and Marguerite Ro, as follows:

On April 19, 2012, the Advisory Committee to the Director Health Disparities Subcommittee met with leadership from the Institute of Medicine (IOM) Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities. Throughout the subcommittee's discussions, several overarching goals were evident and shaped the recommendations in this report:

- Promotion of health equity and health in all policies
- Adoption of place-based strategies that are culturally tailored and appropriate
- Building community and research capacity to tackle health inequities

After reviewing the mission and strategic objectives of the IOM Roundtable and the CDC HDS, both organizations acknowledged the importance of:

1. Coordinating health equity initiatives within and across public and private sectors
2. Aligning resources at different levels for maximum effect and sustainability
3. Understanding the "lessons learned" from the on-going work that can inform current and future work in addressing disparities

Consequently, the CDC HDS was charged with developing specific recommendations to be presented to the Advisory Committee to the CDC Director regarding how to promote further research, program development, and resource allocation around health disparities and health equity. A subgroup of the CDC HDS met and identified five core recommendations for consideration:

1. Frame health equity and define what it means to adopt a health equity lens
2. Identify robust indicators of health equity
3. Foster national health equity initiatives that augment disparity "gap" approaches
4. Build capacity and promote sustainability of health equity programs, especially among vulnerable communities
5. Support public health infrastructure to promote health equity



1. Frame health equity and define what it means to adopt a health equity lens

Discussion

CDC has an opportunity to help define health equity for the agency and the field of public health at-large. While there are various definitions of health equity, a central tenet in all health definitions is a fundamental connectedness between economic and social inequality and disparities in health, and ultimately equity. Communication of that message is critical to the broad understanding, acceptance, and sustainability of health equity work. CDC is charged with developing and implementing programs that have the greatest public health impact, achieved mostly through targeted interventions directed at the most vulnerable populations. CDC programs should be structured so that health equity, the state in which all people have “the opportunity to attain their full health potential” is emphasized in its functions, processes, and procedures.

Examples and Implementation Suggestions

- a) CDC’s funding opportunity announcement (FOA) language should define health equity and emphasize the multi-level conditions and environments that promote health or result in disparities. This includes the continuing historical significance of race and other factors contributing to disparities, and socio-political factors that contribute to inequality.
- b) CDC can emphasize the adoption of a health equity approach. For instance, the scoring process for all funding mechanisms should include concrete measures of how equity is assured; for instance, points could be awarded based on equity-based solutions and strategies and inclusion of populations served.

2. Identify robust indicators of health equity

Discussion

A critical step toward the adoption of a health equity lens is the collection of adequate data by race, ethnicity, and gender. Section 4302 of the Affordable Care Act (ACA) calls for standardized data collection on race, ethnicity, sex, and primary language and disability status as related to all national population health surveys to the extent practical. CDC has a major role in assuring the adoption and implementation of these standards. Beyond national data, CDC should support and assist states and localities in adopting these data standards as well. CDC is well-positioned to assist and provide technical support in data collection efforts, and also data analysis, translation, and dissemination.

CDC should improve the ability of academic researchers, health departments, and community-based organizations (CBOs) to apply a health equity lens. CDC should continue to expand its knowledge base on health equity and support efforts to develop health equity indicators for application in research, practice, and service delivery. Data users should be provided with well-validated tools to measure impact of interventions to promote health equity.



Examples and Implementation Suggestions

- a) Define health equity indicators for their use in research, public health practices, and health service delivery.
 - b) Ensure data collection stratified by race, ethnicity and gender while promoting the adoption and use of approaches that control for race in outcomes studies. Using data is harder than collecting it.
 - c) Further develop the definition and/or spectrum of “evidence-based” to acknowledge “practice-based” particularly as related to cultural and historical contexts. Identify ways to build and disseminate the evidence base.
 - d) Encourage evaluators of health equity outcomes to use best available evidence and evaluation instruments as opposed to narrow, scientifically sanctioned methods. This should be done in collaboration with Joint Commission on Accreditation of Healthcare Organizations (Joint Commission; JCAHO), Liaison Committee on Medical Education (LCME), Centers for Medicare & Medicaid Services (CMS), as well as state, territorial and local tribal agencies, etc.
 - e) Ensure proper evaluation and scaling of innovative, neighborhood-based best-practice programs. This will require mobilizing resources to conduct evaluations in communities that do not have readily available financial and political capital.
 - f) Compile and review instruments that assist community-based organizations to engage in evaluation and the measurement and use of health equity indicators. The Connecticut Health Office’s Health Equity Index was cited, as well as the National Association of County and City Health Officials’ (NACCHO) online learning module – Understanding the Roots of Health Inequity.
 - g) Promote the use of more granular health equity (neighborhood and block-level) data to assist in community health planning.
3. Foster health equity initiatives that augment disparity “gap” approaches

Discussion

Exercising universal precautions, that is, taking specific actions that minimize risk for everyone when it is unclear which patients may be affected, may not be sufficient to assure health equity. In other words, universal interventions alone are insufficient to address persistent population-specific disparities. Placed-based, community-based strategies are preferable in that they tend to be more sustainable. Otherwise, health disparities may persist or become exacerbated. As CDC fosters policy, environmental, programmatic, and infrastructure changes, CDC should monitor and determine whether the strategies implemented by CDC are both reducing disparities and promoting health equity.



In its leadership role, CDC fosters national dialogue with other federal agencies, leading institutions, and philanthropic organizations to assure critical examination of health equity and health disparity initiatives and to make visible “best strategies and practices.” Critical questions need to be asked, such as how to configure the Community Transformation Grants (CTG) to maximize community impact that is sustainable. How do we expand political support for CTG and similar programs? How can we be sure that such programs empower communities and truly represent the community perspective? Insight can be gained from nationally recognized programs that highlight capacity-building and policy development, such as the national tobacco program as well as national nutrition policy. In addition to being multi-level, the most effective programs promote community empowerment because they have long-standing funding, beyond traditional two-year funding cycles.

Examples and Implementation Suggestions

- a) Promote multi-pronged, interdisciplinary, place-based, and community-informed initiatives that focus on social determinants of health that are aligned with Healthy People 2020 and have maximum efficiency and outcomes in improving public health.
- b) CDC should work with journals that have established appropriate peer review for community-based practices and programs.
- c) CDC should recommend that communities and organizations have adequate time to engage in cultural and organizational adaptation in order to enhance their external validity.
- d) Cost and cost efficiency should be estimated to determine whether an innovative program can be scaled up and deployed in a larger community. There is a growing need to create new measures for evaluation that will allow the CDC to fund innovative work.
- e) Foster collaboration among leading institutions such as US Department of Housing and Urban Development (HUD), Robert Wood Johnson Foundation (RWJF), Joint Center for Political and Economic Studies, Convergence Partnership, Policy Link, etc. to assure greater alignment of resources at different levels for maximum impact and sustainability. Examples include:
 - Healthy Start Program: targets communities with high poverty rates, with the program goal to improve health of children by reducing infant mortality.
 - Healthy Neighborhoods: Racial and Ethnic Approaches to Community Health (REACH), and Communities Putting Prevention to Work (CPPW). The goal is to stabilize and foster healthy neighborhoods; unhealthy neighborhoods simply do not thrive. They lead to intergenerational poverty, cycles of addictive behaviors, and other problems.



4. Build capacity and promote sustainability of health equity programs, especially among vulnerable communities.

Discussion

Capacity-building, which is built in National Institutes of Health (NIH) grants, should be adopted for funding mechanisms that are not in the biomedical field. Large funding mechanisms such as the Community Transformation Grants emphasize community engagement and as such, the strategies and practices for assuring successful and sustainable transformation are still evolving. CDC can support in capacity-building in its multiple roles of being a funder, provider of technical support, and disseminator of evidence-based and innovative practices.

Examples and Implementation Suggestions

- a) Construct a national repository of tool kits for capacity-building, and ensure that learning objectives are recommended up front for all grants. Such prioritization will ensure the necessary cross training needed for capacity building.
- b) Grant applicants may not have all of the necessary elements to do the proposed work. Some communities merit additional investment and technical assistance to build capacity to move toward a notion of equity across geography
 - Review Community Transformation Grants (CTGs) and other Community-Based Participatory Research (CBPR) efforts. CTGs were structured so that there were opportunities for normative research as well as focused research on preventive health. CTGs should be modified so that communities and institutions can make investments in education, health literacy, transportation policy and other social determinants that promote community health. Future grants should target smaller, more vulnerable communities, especially those that have limited grant-writing capacity.
 - Review Clinical Translation Science Awards (CTSAs). Funding was initially contingent upon engagement with the community. Now it has been recognized that the engagement in some communities was largely superficial. Consequently, there was limited opportunity for these grants to be transformative. In the next round of funding, community engagement cores will no longer be mandated for CTSAs.
 - Ensure that cross cutting themes of improving cultural competence and health literacy are incorporated in all funding proposals



5. Support public health infrastructure to promote health equity

Discussion

Public health agencies at state and local levels serve as stewards of the public's health. As such, public health is charged with leading the effort to reduce the burden of preventable morbidity and mortality. CDC supports public health agencies by providing guidance and coordination of national initiatives, dedicating resources to population-based strategies, and developing a pipeline of public health workers. CDC, in working with the schools of public health, nursing, and medicine, sets the expectations for and helps to define the competencies of our future public health workforce.

Numerous reports including "The Public Health Workforce: An Agenda for the 21st Century" (US Department of Health and Human Services) identify the need to diversify and assure the cultural competency of the public health workforce. CDC through its workforce programs and its work with public health agencies should play a leadership role in developing a public health workforce with the skills and competencies to effectively promote health equity.

Examples and Implementation Strategies

- a) Assure that CDC trainees fulfill public health competencies. This should include the cross-disciplinary perspective on improving health that includes working with various sectors, and skills to address health equity and social determinants of health.
- b) CDC should work with health departments to explore strategies for diversifying the public health workforce and assuring the cultural competency of the existing workforce
- c) CDC should continue to explore strategies to incent minority participation in CDC funded activities:
 - Provide staged capacity-building for vulnerable communities for infrastructure building
 - Incent minority leadership in research and funding opportunities
 - Points for experience in health-disparate communities or representation from health-disparate communities should be added
 - Further, supplemental points could be awarded for students to promote better diversity for recruitment at local universities that train health department workers

Discussion Points

Dr. Liburd stated that in terms of how the recommendations relate to CDC, the HDS essentially would be petitioning Dr. Frieden to adopt this work that needs to be done by the agency. The recommendations are consistent with HHS's larger initiatives, which align with *Healthy People 2020*.

Dr. Williams wondered whether there would be value in cross-referencing the larger initiatives in terms of the HDS recommendations being looked upon more favorably by Dr. Frieden.



Dr. Ross indicated that he had considered cross-referencing the HHS initiatives, and that he had reviewed the language in the larger initiatives at the time the HDS recommendations were being drafted to ensure that there was consistency in the language and terms. He thought using a cross-referencing strategy would be a reasonable approach, particularly to show that the HDS recommendations were not created in a vacuum.

Dr. Bowman requested clarification with regard to whether there would be some type of introduction to the more specific objectives and initiatives. An introduction would be one place to contextualize the specific recommendations to Dr. Frieden in the context of the HHS initiatives.

Dr. Ro indicated that the HDS draft recommendations were formatted similarly to the way in which some of the IOM recommendations are written, such that the report would be brief so that people could read through it quickly.

Dr. Richardson agreed that inclusion of a brief introduction that contextualizes the recommendations, references, and the other major initiatives would be beneficial.

Dr. Duran suggested that the introduction could also specify how the recommendations might be actionable. For example, some of the recommendations may be applicable to language regarding CDC funding opportunities. The introduction could state that some of the recommendations could be enacted via CDC funding opportunities to health departments and communities. Perhaps follow-up could be conducted in a year to determine whether any of the recommendations were actually implemented.

Dr. Pestronk pointed out that because specific recommendations were embedded in the discussion section and referenced as examples and implementation suggestions, it was not entirely clear what specific action the HDS wanted Dr. Frieden to take.

Dr. Ross agreed, pointing out that the way the document was presented for this call was intentional in order to call out various aspects for the sake of discussion. The points of discussion were to internally contextualize the initiatives. The discussion points probably would not be needed in the final recommendations, and would probably become part of the background statement. The final recommendations would include the initiative and a set of examples and implementation suggestions.

Dr. Pestronk thought that would make the document easier to read, easier for Dr. Frieden to understand in terms of whether he wants to adopt any of the recommendations, easier for the committee to determine whether any of the recommendations have been adopted, and subsequently easier to determine whether the recommendations have made a difference anywhere. In addition, in Section 1, "health equity" and "health equity lens" need to be clearly defined. In terms of the recommendations in that section, it is not simply that FOA language should incorporate the ideas and seek means to address health equity and the use of a health equity lens. It is also that programs, centers, and offices within CDC that are focused on disease, conditions, and processes also need to be trained to accept and understand health equity, and need to incorporate the definition and understanding into their work. In addition, it is not simply the question of programs. Health equity should also be rooted in political work. While he was not clear whether they would be able to discuss political work in the initial set of recommendations that HDS put forward, somehow the notion of political action could change



the decision-making processes and the way in which people in communities participate in those. That did not come through as clearly as it might. He was not sure that the recommendations were strong enough, regardless of what one's work is at CDC. There are some very powerful recommendations embedded in the discussion sections that do not come across in the examples and implementations suggestions.

Dr. Ross clarified that the second and third sentences on page 2 should be a suggestion or a recommendation going under the notion of parsimony, but details could be further fleshed out.

It struck Dr. Ryder that there was an opportunity in Strategy #2 to be somewhat more specific about not only the ability of academic researchers, health departments, and community-based organizations, but also primary care organizations. At the Health Resources and Services Administration (HRSA) level, there has been a major focus, especially within primary health care, to integrate public health and primary care. The recommendations offer an opportunity to reinforce that as a way of forging that integration. Suggested language: primary care institutions, primary care organizations, primary care providers, primary care provider organizations, community health centers. Dr. Ross indicated that the subgroup would work on the specific language.

Dr. Williams suggested some friendly amendments that could enhance the language. For example, in Section 2: Identifying Robust Indicators of Health Equity, he thought it was important to emphasize the importance of stratifying data by race, ethnicity, gender, and socioeconomic status. This would change the understanding inequality, and would help to limit some of the racialization that occurs in the mind of someone who sees data by race and ethnicity. The National Committee on Vital and Health Statistics (NCVHS) has recommended stratification by race, ethnicity, gender, and socioeconomic status for some time. NCVHS does this more in the US than they used to, but still does not do so routinely.

Dr. Pestronk noted that there are also indicators that have been adopted already, or have been recommended for adoption. For instance, perhaps reference the *Expert Review and Proposals for Measurement of Health Inequalities in the European Union*, combined specific demographic, economic, and race indicators into rates and ratios which would encourage some standardization and allow some contrast between the US and neighborhoods within the US, as well as other parts of the world. Perhaps this should be referenced [Spinakis A, Anastasiou G, Panousis V, Spiliopoulos K, Palaiologou S, Yfantopoulos J. Expert review and proposals for measurement of health inequalities in the European Union - Full Report. (2011) European Commission Directorate General for Health and Consumers. Luxembourg. ISBN 978-92-79-18528-1].

Dr. Pestronk pointed out some other minor issues in the draft recommendations that needed attention, including the following:

- Page 4, Recommendation 3, “convergent partnerships” should be “convergence partnerships.”
- In B in that same list of recommendations, “CDC should work with journals that have established appropriate peer review . . .” should read “practice-based peer review.”
- Under Strategic Initiative # 4, the example in implementation suggestion D should reference Community Transformation Grants because those are within CDC, but larger funding has been allocated from NIH through CTAs. Perhaps Center for Medicare and Medicaid Innovation (CMI) grants should also be referenced here as well.



- In terms of public health infrastructure, the actual suggestions and examples are exclusively workforce-related. It is not sufficient to talk about the workforce. There needs to be funding to support that workforce in state and local health departments, for example. Those are a different kind of capability. One recommendation is having a workforce that looks and thinks in a particular way. The other is to recommend that there are financial resources to support that workforce.

Dr. Ross thought they had captured the need for funding of the public health workforce, and was going to make a comment about the Prevention and Public Health Fund as the mechanism by which to do this, but the subgroup thought it would be too political, so they left it out.

Given the time, Dr. Richardson requested that further comments and suggestions be submitted via email within a week so that the workgroup could synthesize them in order to complete a final draft by approximately mid-February. She also wanted to be able to include something from the subcommittee on the ACD's April 2013 agenda, at least a version for which feedback could be solicited. She indicated that she would like to build in time prior to that for the full HDS to review the next iteration.



Dr. Ross concluded that following this HDS meeting, he and Drs. Duran and Ro would redraft the recommendations to include everyone's suggestions, and would present the full HDS with the formal recommendations during the in-person April 2013 HDS meeting in order to codify the recommendations.

Public Comment Period

No public comments were offered during this meeting.

Wrap Up / Adjournment

Dr. Richardson thanked HDS members and CDC staff for their time and participation. She particularly thanked Drs. Ross, Duran, and Ro for their yeoman's work in developing the draft recommendations document. She reported that a full agenda was expected for the April 24, 2013 HDS meeting, and that she planned to distribute a draft agenda for members to review and make any suggestions they thought would be beneficial. The meeting will be convened in Atlanta, and Dr. Richardson anticipated it to be an important meeting in terms of the work plan for the subcommittee for the coming year. She reminded everyone that she planned to introduce into the agenda a series of presentations from CDC Center Directors. Her intent is to provide the directors with a fairly structured set of questions so that they can frame their presentations in terms of how they are incorporating health equity into the work of their respective centers. This should enable the HDS to determine the extent to which this work is being embedded throughout CDC programming.

With no further business posed or questions raised, Dr. Richardson officially adjourned the meeting.



Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the January 23, 2013, meeting of the Health Disparities Subcommittee of the Advisory Committee to the Director, CDC are accurate and complete.

Date

Lynne D. Richardson, MD, FACEP
Chair, Health Disparities Subcommittee
Advisory Committee to the Director, CDC



Attachment #1: Meeting Attendance

HDS Members Present:

Bowman, Phillip, PhD

Director and Professor Diversity Issues in Health Disparities Initiative
National Center for Institutional Diversity
The University of Michigan
(via teleconference)

Duran, Bonnie M., MPH, DrPH

Associate Professor, Health Services
University of Washington
(via teleconference)

Jackson, Fleda Mask, PhD

President and CEO Majaica, LLC

Mullen, Jewel M., MD, MPH, MA

Commissioner and State Health Officer
Connecticut Department of Public Health
(via teleconference)

Pestronk, Robert M., MPH

Executive Director
National Association of County and City Health Officials
(via teleconference)

Richardson, Lynne D., MD, FACEP

Chair, Health Disparities Subcommittee
Professor of Emergency Medicine and of Health Evidence and Policy
Vice Chair for Academic, Research and Community Programs
Department of Emergency Medicine
Mount Sinai School of Medicine
(via video conference)

Ro, Marguerite, DrPH

Chief Assessment, Policy Development, and Evaluation Section
Public Health Seattle – King County
(via teleconference)

Ross, Will, MD, MPH

Associate Dean for Diversity and Associate Professor of Medicine
Office of Diversity
Washington University School of Medicine



Ryder, Bobbi

President and CEO
National Center for Farmworker Health, Inc.
(via teleconference)

Williams, David, PhD

Florence and Laura Norman Professor of Public Health
Professor of African & African American Studies
Harvard School of Public Health

CDC Staff Present:

Baker, Gwen

Program Specialist
Office of Minority Health and Health Equity

Hall, Mary E.

Public Health Analyst
Office of Minority Health and Health Equity

Hickman, Gayle J.

Committee Management Specialist, ACD
Advance Team, Office of the Chief of Staff

Liburd, Leandris, MPH, PhD

Director
Office of Minority Health and Health Equity

General Public Present:

Beury, Kim

Community Health Funding Report
Community Development Publications
Washington, DC Based Newsletter

Henry-Gonzalez, Sarah J.

Medical & Scientific Writer/Editor
Cambridge Communications & Training Institute

Wallace, Stephanie

Medical & Scientific Writer/Editor
Cambridge Communications & Training Institute



Attachment #2: Acronyms Used in this Document

Acronym	Expansion
ACA	Affordable Care Act
ACD	Advisory Committee to the Director
CBOs	Community-Based Organizations
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPPW	Communities Putting Prevention to Work
CTG	Community Transformation Grants
CTSA	Clinical Translation Science Awards
FOA	Funding Opportunity Announcement
HDS	Health Disparities Subcommittee
HHS	(United States Department of) Health and Human Services
HP	Healthy People
HRSA	Health Resources and Services Administration
HUD	(United States Department of) Housing and Urban Development
IOM	Institute of Medicine
Joint Commission; JCAHO	Commission on Accreditation of Healthcare Organizations
LCME	Liaison Committee on Medical Education
NACCHO	National Association of County and City Health Officials
NCVHS	National Committee on Vital and Health Statistics
REACH	Racial and Ethnic Approaches to Community Health
RWJF	Robert Wood Johnson Foundation
US	United States

