



Minutes from the  
November 12-13, 2014

CDC Advisory Committee  
to the Director  
Health Disparities  
Subcommittee

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## Advisory Committee to the Director Health Disparities Subcommittee Record of the November 12-13, 2014 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 November 12-13, 2014 via teleconference. The agenda topics included an Office of Minority Health and Health Equity (OMHHE) update; a CDC update; a progress report on the 2014 HDS recommendations, a discussion regarding collaboration with the State, Tribal, Local, and Territorial Subcommittee (STLT) and other advisory committees; an update on HDS priorities; and an overview of the Office of Women's Health and Diversity and Inclusion Management.

### Roll Call / Welcome and Overview of the Meeting

Lynne Richardson, MD, FACEP, Chair, HDS, called the CDC HDS to order at 2:00 pm on Wednesday, November 12, 2014 and at 9:00 am on Thursday, November 13, 2014. Ms. Gwen Baker, Program Specialist, OMHHE, CDC, called the roll on November 12-13, 2014. A quorum of HDS members was present each day. New and returning HDS members, CDC staff, and others present introduced themselves. With regard to conflicts of interest (COIs), Nisha Botchwey disclosed that she receives CDC funding. No other disclosures were reported. A participant list is appended to this document as Attachment #1.

### Updates from the Office of Minority Health and Health Equity

Leandris Liburd, MPH, PhD, Associate Director for Minority Health and Health Equity, CDC, and Designated Federal Official (DFO), HDS, welcomed the group and thanked them for their participation. She recognized and congratulated the following members for recent achievements:

- Dr. Will Ross has been promoted to Professor of Medicine.
- Dr. Jewell Mullen has risen to the rank of President of the Association of State and Territorial Health Officials (ASTHO), and has indicated that the President's Challenge will focus on healthy aging.
- Dr. Lynne Richardson received the Colin C. Rorrie Jr. Award for Excellence in Health Policy Award. This award is presented to a person of distinction who has made significant contributions in achieving the health policy objectives of the American College of Emergency Physicians (ACEP).
- Mary Hall plays a very important role with the HDS, but was absent due to illness.

Dr. Liburd presented an update of OMHHE activities since the August 2014 HDS meeting. OMHHE will have its second Quarterly Program Review on December 1, 2014, offering the opportunity to update Senior Leaders on OMHHE's progress over the last six months on some key priorities, and to discuss future directions. OMHHE's key priorities are:

- Increasing the number and breadth of evaluated interventions in the periodic *Morbidity and Mortality Weekly Report (MMWR)* report, "CDC Report on Strategies for Reducing Health Disparities"
- Increasing the diversity and skill of the emerging public health workforce that is trained by the CDC Undergraduate Public Health Scholars Program (CUPS)



- ❑ Increasing women's use of ACA preventive services, including recommended screenings and contraceptive services, and
- ❑ Increasing the number of diversity competent mentors at CDC

OMHHE also completed its strategic planning process, integrating the Office of Women's Health (OWH) and the Diversity and Inclusion Management activity into the office. In terms of this new structure and the restructuring of the office, Dr. Liburd requested the HDS's specific input on ways OMHHE might maximize the impact of having these three units working together. While women are a slight majority in this county, in terms of the health status of women and other sociodemographic factors related to women, they certainly fit within OMHHE's focus of achieving health equity.

OMHHE welcomed the third cohort of the CDC Undergraduate Public Health Scholars Program (CUPS) May 28-30, 2014 for an orientation to the program. Students were welcomed by Dr. Frieden. Over the course of the two days, students learned about a variety of CDC priorities, as well as the career trajectories of many scientists at the agency and more broadly.

Over the last six months, OMHHE has been working to link CUPS with CDC's Public Health Associates Program (PHAP) by establishing a formal collaboration with the PHAP team, which resides in the Office for State, Tribal, Local, and Territorial Support (OSTLTS). PHAP is essentially a program that places recent graduates in local health programs for two years. They are linked to the agency, but are working locally.

OMHHE has included members of the PHAP team in the CUPS evaluation workgroup, and is beginning to share data and review the demographic characteristics of the individuals in both programs. One of the goals for the CUPS program is for CUPS alumni who are interested and eligible to apply for the PHAP program. This year's PHAP cohort includes three former CUPS students. The PHAP program receives approximately 6000 to 7000 applications for about 160 slots, so OMHHE is thrilled that three of the CUPS students have been accepted.

OMHHE's Science Team is currently working on the second edition of the *MMWR: CDC Report on Strategies to Reduce Health Disparities*, the first of which was published last April. The next edition, which is anticipated to be released next Fall, will feature an increase in the number of interventions and the scope of these interventions. Some people say that health disparities have existed for a long time and have seen the data, but they wonder what is being done to reduce health disparities. Others do not believe that racial and ethnic health disparities can be reduced.

Through the authoritative mechanism of the *MMWR*, OMHHE wanted to demonstrate that CDC has implemented, evaluated, and broadly disseminated strategies that are working. OMHHE is continuing to publish this report because it was well-received. It is possible to track how many times each article is downloaded, as well as how many members of the press did some sort of coverage of the publication. However, it is not possible to track what occurs after that. There is more work to do in terms of translating this from a highly technical scientific manuscript into language that can be used locally by those who may wish to implement some of these interventions in their communities. OMHHE is excited about continuing with this effort.



The Millennial Health Leaders Summit activity is part of the workforce and professional development recommendation and goal. The first Summit was held in April 2013, and OMMHE convened its second cohort in October 2014. The Summit brings together a cadre of medical, graduate public health, and policy students who are nominated by their universities for their outstanding achievements and promise as future leaders in addressing health disparities across the nation.

The Summit was developed by OMMHE in collaboration with the Harvard School of Public Health, the University of North Carolina, Chapel Hill Gillings School of Global Public Health, and Brown University. It is designed to provide students who will soon enter the workforce with a greater understanding of the complex issues facing communities disproportionately affected by health disparities. A planning committee works together over the course of the year to structure the Summit. The universities sponsor their students' participation, and have published some very nice press through their newsletters and other media about the students' feedback on this opportunity and how they plan to use the experience as they move through their training.

October's Summit brought together 55 students from 18 schools for two days of workshops and case studies on topics such as community organizing, multi-sectoral collaboration, strategies for reducing disparities, and career development. The following is a photograph of the entire 2014 Summit group:



**2014 Summit Group**



The State of Health Equity at CDC Forum convened earlier on November 12, which was attended by some HDS members. It was the third in a series of five events organized by OMHHE since 2012. The Forum is tied closely to the first recommendation made by HDS, which is to develop a framework for action to achieve health equity. This recommendation is being directly addressed by this series of internal Forum events. For those not able to attend the morning's Forum, these events are designed to bring together a variety of disciplines across the agency to examine key aspects of health equity, namely measurement and indicators, articulating essential elements of programs, policies to support health equity, and infrastructure necessary at CDC to carry this work out. Four papers are being developed on the four themes of the Forum series, which include: Measurement, Program, Policy, and Infrastructure. The next forum is planned for the Fall of 2014, which will focus on policy.

In terms of additional activities, OMHHE is leading the development of the second annual update of its agency Language Access Plan to submit to HHS early in 2015. This Plan responds to Executive Order 13166 intended to "improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP)." The 2013 report presented the results of OMHHE's efforts to inventory and describe current language access services provided by CDC. The focus of this year's report will be on examination of internal procedures, as well as progress toward disseminating examples of these practices.

OMHHE is also leading the development of a Vitalsigns™ report on Hispanic health, which is a monthly report released the first Tuesday of each month that focuses on highly visible issues and presents a data brief and actionable messages. The current Vitalsigns™ had a focus on cervical cancer and was released the week before this HDS meeting. The Vitalsigns™ focused on Hispanic health will be descriptive in terms of Hispanic health issues and strategies for improvement. The target date for that issue is May 2015.

Dr. Liburd also mentioned an upcoming exciting collaboration that OMHHE has with Tuskegee University, Morehouse School of Medicine, and Atlanta University Center on a program to commemorate the life of Booker T. Washington. Booker T. Washington is significant in that he was the creator of Negro Health Week, which ultimately evolved to be Minority Health Month. He was also the Founder of Tuskegee University, so the university is planning a year-long celebration commemorating his life and legacy. The focus of the collaboration with OMHHE will be a 100-year retrospective of the health of African Americans.

OMHHE is in the process of identifying speakers such as Lewis Sullivan, the Founder of Morehouse School of Medicine; Dr. David Satcher, the 10<sup>th</sup> Assistant Secretary for Health (ASH) and the 16<sup>th</sup> Surgeon General of the United States (US); Dr. David Williams, Dr. Vivian Penn, and other "giants." OMHHE also hopes to provide scholarships for students to spend the day at CDC hearing plenary presentations from the "giants" and attending workshops in the afternoon that focus on contemporary health issues impacting African Americans, particularly African American youth, such as HIV among young MSM, obesity rates among African American women 18 years of age and older, and other issues. The goal is to have the students leave with a Call to Action to continue to pursue better health, because Booker T. Washington



connected it with the economic viability of the community. OMHHE is planning for the event to take place April 17, 2015.

The National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD) has committed to serve as an Envision site, and the hope is to have Envisions sites throughout the country in order to allow more student participation. OMHHE views this as an opportunity to raise awareness about African American health, and to look retrospectively at the work that has been achieved and the work that still needs to be accomplished.

### **Discussion Points**

Dr. Richardson asked Dr. Liburd to elaborate on what was meant by “Diversity Competent Mentors.”

Dr. Liburd replied that the student program was the impetus for Diversity Competent Mentors. OMHHE seeks mentors from throughout the agency to work with students, but finds that they are not all culturally competent to work with students from diverse backgrounds and perspectives. Since being diversity competent and being a mentor are skills, OMHHE views this as a dual strategy to create greater diversity awareness and competence across the agency so that staff and colleagues also benefit and sensitivity is created about differences and similarities that exist in the agency. The hope is that this will increase productivity and enhance inclusion. About 50 people were recently trained.

Dr. Johnson inquired as to whether there was any potential to expand the language access program to people who are deaf and have limited English proficiency for that reason.

Mr. Dicient-Taillepierre responded that a disability framework is being folded into the Language Access Plan effort. The current focus is on examples of policies and practices that are desired across the agency, and that should be included in Funding Opportunity Announcements (FOAs). There have already been some discussions with members of the HDS about language that would go into FOAs. The process began with language in terms of foreign-born populations, for example Spanish as a proxy, to get through a dynamic of discussion within CDC. However, there will be a focus on other elements moving forward. Conversations are underway with senior CDC leaders regarding policy and funding implications. The specific examples have been focused on language, but not because disability has not been a focus as well.

Ms. Wilson wondered whether she could provide assistance, given that one of her areas of expertise is language access. Executive Order 13166 mirrors Title VI for the Civil Rights Act, which deals specifically with language access, national origin, discrimination, et cetera. She offered to discuss this further offline with Dr. Liburd and Mr. Dicient-Taillepierre.



Dr. Ro praised the public health training programs. A lot of work has been discussed beginning early and building up the pipeline, including the pipeline into governmental public health at all levels. While she did not readily know the retention rates of how many people go into public health and want to stay, she emphasized the importance of mid-level to executive leadership training as well, particularly for people of color to break through the glass ceiling and make it into the ranks. She noted that during Washington's state meeting of executive leadership from throughout the state, she was one of a handful of people of color in a leadership position in Washington State. That is unfortunate. There is work that must be done. There are others, especially with the American Medical Association (AMA), who are also very interested in executive leadership. Engaging in partnerships with the healthcare sector and public health is a potential area of interest.

Dr. Liburd asked Dr. Mullen whether ASTHO collects information about leadership and diversity, particularly state health department leadership. She asked if anyone knew whether the National Association of County and City Health Officials (NACCHO) and/or others are monitoring these trends. Dr. Ro indicated that she would follow-up with NACCHO.

Dr. Ross indicated that a particular charge of the Coordinating Council Public Health Committee is to address workforce diversity in schools of medicine, schools of public health, and within the workforce. With a clear recognition of a deficiency, there is a goal to query ASTHO, NACCHO, schools of medicine, and schools of public health to assess who is there in what capacities (e.g., training, upper level management, senior management, administrative). There is simply not a database at this point.

### **Progress Report Highlights: 2014 Recommendations**

Dr. Richardson reminded everyone that in April 2014, the ACD passed a set of recommendations that were put forward by the HDS pertaining to how to accelerate progress toward health equity goals across the agency. During this session, progress updates were given on the Framework for Health Equity Action, Training Indicators, and STLT Social Determinants of Health (SDOH) Recommendations.

### **Framework for Health Equity Action**

In terms of the framework, Dr. Liburd reported that OHMME is in the process of developing manuscripts based on the four components (e.g., measurement and indicators, essential program elements, policies to support health equity, and infrastructure). The goal is to have those manuscripts written and cleared by CDC by the end of February. They will then be peer-reviewed through the *Journal of Public Health Management and Practice*. Dr. Liburd will lead the writing of a synthesis paper that will synthesize the other four components. That will inform the articulation of the Framework for Health Equity Action, which should be determined by November 2015.



## **Training and Composition of the Public Health Workforce to Address Health Equity**

CAPT Craig Wilkins, Acting Associate Director for Tribal Support, OHMME offered an update on Recommendation 6: Support Training and Composition of the Public Health Workforce to Address Health Equity. OHMME has convened a small workgroup, which recently conducted its first meeting to consider this recommendation. There will continue to be monthly meetings moving forward. This workgroup is comprised primarily of representatives from CDC's centers, institutes, and offices (CIOs) who are already engaged in workforce and pipeline programs. A couple of other workgroup members from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) were unable to attend the first meeting, but OHMME will engage with them in the future.

One of the primary charges of the workgroup is to identify existing and needed training resources. The workgroup plans to examine current initiatives and resources within and outside of CDC to gauge the areas of workforce and pipeline programs, and the potential of those programs to address public health issues in terms of achieving health equity. Part of the initial scan will address adequacy of training content and competencies. Another issue discussed during the first workgroup meeting that CAPT Wilkins thought was critical with regard to this recommendation pertained to who will receive this type of training and what offices will be involved in dissemination of this training.

Moving forward, this process will align with the STLT SDOH workgroup recommendation, which is considering leveraging training for STLT agencies on SDOH. Part of the recommendation for engagement is the development of a plan for the direction of training opportunities. Once the OMHHE's initial review is completed, part of the OMHHE's workgroup's discussion of next steps will be regarding the identification of training recipients (e.g., PHAP, project officers, state and local health departments currently engaged in health equity, and others). That will be followed by the development of a training program.

CAPT Wilkins and his workgroup have shared a reference list of national resources on health equity, which OMHHE's workgroup is currently reviewing. During the first OMHHE workgroup meeting, there was discussion about creating a fishbone strategy to frame the initial scan for existing resources at the agency. A draft proposal of this scan was developed by a smaller group of subject matter experts within the OMHHE workgroup, who will be meeting next week with Dr. Liburd and others within OMHHE. The draft proposal will then be presented to the larger workgroup for consensus on whether to move forward on this type of strategy based on the initial scan of existing resources within the agency.

There are some challenges, such as time management and the time and efforts required for the initial scan. There was discussion during the first workgroup meeting regarding the development of the right approach and strategies for sustainability moving forward, as well as determining the cultural competencies that are known to be critical for this recommendation.



## **Discussion Points**

Dr. Botchwey asked what consideration has been given to evaluation of the training content developed and delivered beyond the initial training to ensure that the training is actually meeting the needs of the workforce.

CAPT Wilkins replied that this has not been part of the discussion thus far, but the workgroup is aware that this will need to be addressed moving forward.

Dr. Ro asked what success would look like.

CAPT Wilkins responded that for himself and the workgroup, success will be defined as the initial scan is done and there is discussion about development of the training program and determination of the recipients of the program.

Dr. Ro suggested taking into consideration the question, “What difference does having completed the training make?” She thought everyone would be interested in and supportive of whatever that goal is.

Dr. Liburd added that for her, the goal would be observation of the fruit of the training expressed through the work being done. For example, CDC Project Officers should be able to provide better technical assistance to their grantees regarding health equity. That should then result in better program implementation, program management, evaluation, et cetera. CDC must begin with understanding the competencies the agency needs to have to structure cooperative agreements that will facilitate health equity work. People say to her, “What do you mean by health equity? What is that? What does that look like?” She thought Leonard Jack alluded to that in his comments during the Summit that looking across the nation, there is a lot of variance in terms of capacity within state and local health departments to do this kind of work. Without a broader view of what people are doing, what they are inclined to do, or what they have the resources to do, it is very different. If CDC could build that capacity beginning with the agency first, that will hopefully contribute to outcomes later in the continuum.

Ms. Wilson added that this applied to what Dr. Williams said in his comments about intersectionality. She recently did a webinar for a Substance Abuse and Mental Health Services Administration (SAMHSA) grantee in Montana. Those living with poverty and lack of education do the most poorly. Until disparities are addressed among all types of groups through a variety of lenses and people are trained, and in the absence of data, people will not know what they do not know. People who are unaware of what they themselves do not know cannot possibly provide technical assistance to those with whom they are working.

Mr. Vargas encouraged the workgroup to think about how this training can be delivered above the Project Officer level so that managers know how to hold Project Officers accountable for the competencies they are being trained to implement with grantees.

Dr. Ross added that it is important to evaluate the institution and health departments for implicit bias as the training is being delivered. There are validated instruments that can assess implicit



bias and inform the thinking about how to identify potential leaders and use objective measures to elevate them.

Ms. Wilson indicated that her cultural competency trainings include a module on unconscious bias.

Dr. Liburd reported that a recommendation has been made to CDC to address unconscious bias internally. The agency is very cognizant that it has its own work to do internally, which is what the forums and training are about.

### **Indicators of Health Equity**

Ana Penman-Aguilar, PhD, MPH, Associate Director for Science/Science Team Lead, OMHHE presented an update on Recommendation 2: Identify and Monitor Indicators of Health Equity. A Cross-CIO workgroup was formed in August 2014 to address the HDS recommendations. Two meetings of larger groups have been convened so far. In addition to the Health Equity Indicator (HEI) recommendation, the same group is working on the non-health data source recommendation by the STLT subcommittee. The subgroup of the Cross-CIO workgroup Dr. Penman-Aguilar is working with was formed in September 2014 specifically to address the HEI recommendation. This group is comprised of members who are broadly reflective of CDC, and has convened three meetings so far. The charge of the HEI Subgroup is to further refine and respond to recommendations adopted by the ACD on the identification and monitoring of indicators of health equity.

The HEI Subgroup action plan is to:

1. Examine existing efforts under way at CDC and outside of CDC to monitor SDH at a national level
2. Develop criteria for choosing indicators (not limited to SDH)
3. Select indicators and their corresponding data sources
4. Identify data gaps – what we need to know but can't know at this time
5. Propose best approach for monitoring selected indicators
6. Propose best approach for reporting on selected indicators

One of the first questions the HEI Subgroup members asked Dr. Penman-Aguilar was what was meant by “indicators of health equity” and “monitoring health equity.” The following is a draft working definition of health equity indicators, which she put forward for HDS members’ input:

“A set of indicators reflective of the state of national health equity that will be useful to both assess magnitude of differences in adverse outcomes among groups and document persistence of circumstances of living suspected to underlie adverse outcomes.”



## Discussion Points

Dr. Ro encouraged the group to work with the many communities across the nation who are engaged in equity work. For instance, King County has conducted a health equity exercise and has selected 14 determinants of equity for the county that include the built environment, safety, law and justice, health, education, et cetera. They are now working to determine what data are available to allow them to monitor progress. She also encouraged them to reflect on Dr. Williams' comments earlier in the morning regarding intersectionality and consider setting that as a standard, which could make a great contribution. Setting that as a national standard may be difficult at first because many epidemiologists will say that they cannot do this, but if they are pushed harder, they will find a way. This will also emphasize the data that need to be collected in order to be able to do this.

Dr. Penman-Aguilar strongly agreed, noting that the manuscripts being developed for the supplement might be a good place to make that point as well.

Dr. Richardson thought it would be a good idea to include this in the manuscript, and stressed the importance of understanding the various data sources and indicators to decide the most appropriate set. It is also important to consider what data are needed for which there currently are no data sources, and how to encourage the collection of those data. Otherwise, they will always be limited to what is already being measured. While she understands all of the challenges involved, that will be necessary once the gaps are determined.

Dr. Williams thought this could be pulled out as a separate bullet to determine what to do for small populations for which there will never be a national study that will have enough data. Pacific Islanders and Native Americans are two examples. CDC has shown a wonderful way to do this by accumulating data over four or five years. Although there are never enough Asians or Native Americans in the National Health Interview Survey (NHIS) to have separate categories, when data are accumulated over four or five years, it is possible to prepare a special report on the health of smaller groups using the NHIS data. A lot of times people do not even think about strategies such as that. To emphasize how large the nativity issue is, they have been doing some work in Chicago using a representative sample of adults in the City of Chicago, which is approximately one-third black, one-third white, and one-third Latino. For every indicator published (e.g., stress levels, sleep levels, health status indicators, et cetera), Latinos are intermediate between blacks and whites. When Latinos are separated by US- or foreign-born, US-born Latinos do not differ from African Americans and foreign born Latinos do not differ from whites. By assessing nativity, completely different patterns emerge. For a public health official trying to address the needs of the Latino populations, knowing whether the population is US- or foreign-born tells a lot about the health profile that would be missed completely by just having Latinos as a category.

Dr. Penman-Aguilar indicated that when they meet with the Vitalsigns™ group on Friday, they plan to propose that everything in the report be stratified by US- versus foreign-born.



Dr. Williams indicated that there is a National Health and Nutrition Examination Survey (NHANES) paper by Arline T. Geronimus looking at Mexicans that, rather than self-reported health measures, used a 10-item measure of health status (e.g., blood pressure, inflammation, et cetera). The paper found that Mexican immigrants who have been in the US zero to five years look like whites on the Allostatic Load (AL) Profile. At 21 or more years, they look like African Americans.

Dr. Penman-Aguilar indicated that the other group that has been advocating for this for some time is the Hispanic Health Workgroup. Regarding Dr. Ro's point, OSTLTS's work with state and local groups on monitoring health equity is spot on. Dr. Penman-Aguilar's workgroup can leverage that as well, because the two workgroups are connected.

Dr. Botchwey indicated that she works at the neighborhood level. At that level, it is very difficult to acquire data. She wondered whether the workgroup might consider ways to look for data that does not exist currently at the sub-county scale in order to better target interventions for geographically-based populations.

Dr. Ro indicated that King County tries to get the data down to the Census tract level and is most challenged by validation of the small area estimates. From a methodological standpoint, it would be extremely beneficial if CDC could do this work.

Dr. Williams thought it might be worth contacting <http://www.countyhealthrankings.org/> and the people at CDC who work with them. Even at the county level, estimates of health are provided. This is a place to look for potential equity indicators as well, because they provide indicators of health status and the determinants of health status for every county in every state. Some counties are very large and others are very small. For them to be able to provide this information for every county in every state, they work with counties with very small populations and CDC to estimate averages across multiple counties.

Dr. Botchwey thought it might also be beneficial to have a conversation with people at NACCHO, especially in terms of thinking about working with county health departments and the data that they have readily available. Perhaps suggestions could be made to help NACCHO think about how to package those data so they are useful to CDC and others in a more direct, transparent way while still protecting the identity of the individuals who are surveyed.

Dr. Ro noted that she did not see Chesley Richards on the list of workgroup members, and suggested that they touch base with him since he is interested in this—especially with regard to what systems need to be in place to get these data out. The beauty of the county health rankings is that the majority of counties across the US, which are smaller populations, do not have the infrastructure to generate and produce all of the data that those at a larger county or state level can.

Dr. Penman-Aguilar responded that three people from Chesley Richards' unit are on working with the STLT SDOH Think Tank workgroup. They are great resources for both workgroups, so Dr. Penman-Aguilar will make contact with him as well.



### STLTS SDOH Recommendations

Ms. Judith Lipshutz, MPH, Public Health Analyst in the Office of the Director of OSTLTS indicated that the STLT Subcommittee is comprised of state, tribal, local, and territorial Health Officers from throughout the country or people who have been in those positions. A couple of members serve on the ACD as well, so there is a lot of cross-over. In terms of structure, the STLT Subcommittee is parallel to the HDS Subcommittee under the ACD.

The STLT is subdivided into Think Tanks that each focus on a specific area of interest. Currently, there are three functional Think Tanks: Public Health Think Tank, Social Determinants of Health Think Tank, and Public Health Finance Think Tank. The CDC Cross-CIO Workgroup has been added, which addresses the health indicators recommendations from the HDS Subcommittee as well as the social determinants of health recommendations from the STLT Subcommittee. This structure is depicted in the following graphic:



The charge of the STLT Subcommittee SDH Think Tank is to identify ways CDC can help STLT public health agencies productively contribute to addressing social determinants of health in their communities beyond existing efforts. To do this, there is a current focus on: 1) building upon the recommendations related to non-health data sources and staff training adopted by the ACD on April 24, 2014; and 2) identifying how public health can strengthen its role in supporting interventions that address SDOH, including overcoming barriers (e.g., legal, political, non-traditional partnerships).

The SDOH Think Tank was initiated and first began meeting in February 2014. The most recent meeting was convened on September 23, 2014. As mentioned, two recommendations were adopted by the ACD in April 2014. The CDC Cross-CIO SME Workgroup was formed internally in August 2014 to address the recommendations. Thus far, the focus of the group has been on non-health data source recommendation. There has been some preliminary work in the training area as well. The same group will be working on the HEI recommendation adopted by ACD in April 2014.



The STLT SDOH recommendations are as follows:

*STLT Recommendation 1: Aligns with HDS Recommendation 2: Identify and Monitor Indicators of Health Equity*

- ❑ CDC should explore the available non-health data sources from other domains (e.g., housing, human services, education, transportation, public safety, income) that are readily available and that offer insights into the impact of the social determinants of health. CDC should also explore ways STLT health agencies can collect and incorporate such data in their planning.

*STLT Recommendation 2: Aligns with HDS Recommendation 6: Support Training and Professional Development of the Public Health Workforce to Address Health Equity*

- ❑ CDC should develop a plan to either leverage existing informational and skill-building training opportunities for STLT agencies on how to incorporate SDOH practices or develop new training opportunities where needed. Trainings might be directed at:
  - Project officers
  - New and mid-career public health workforce
  - Public health leadership
  - Non-traditional public health workforce (e.g., social workers, community health workers)
  - Local Boards of Health

To address STLT's Recommendation 1, the internal group first began to figure out what resources exist. While they found a number of existing resources, health departments do not necessarily know about or use them, they are not easily accessible, and they are not coordinated in one place. One of the tools identified within CDC was the Community Health Status Indicators (CHSI) tool, which had not been updated until the last couple of years. It is expected to go live from CDC soon. The workgroup focused on that tool because it tends to address the concerns identified in the beginning, includes multiple SDOH and links to indicator measures, and it goes down to the county level and in many cases the zip code level depending upon the non-health data sources. This tool is expected to receive CDC clearance within the next two months.

The group also discussed how those indicators could potentially link to interventions, so they investigated what databases exist that are related to interventions. The most obvious within CDC is the *Community Guide*, but strict criteria must be met to get into this database and very few interventions pertain to social determinants of health at this point. A Community Health Improvement Technical Packet is being developed for not-for-profit hospitals in response to the requirement by the Affordable Care Act (ACA) that they have some type of community benefit. That is being developed with the Office of Policy at CDC and is anticipated to be completed by December 2014 so that it is available for use by hospitals when they have to start their new tax cycle and have to meet the community benefit requirement. Another resource identified by the



workgroup was Healthy People 2020, which recently published some interventions related to social determinants of health.

On October 10, 2014, the STLT Subcommittee met in person and adopted another recommendation related to social determinants of health, which focuses on the CHSI and similar tools that can bring together multiple databases. That recommendation follows:

- ❑ CDC should endorse and support expansion of approaches like the Community Health Status Indicators tool (CHSI) to assist health departments better understand and modify SDOH in their jurisdictions:
  - Special attention should be paid to the timeliness of data and to their direct application to actions that improve the health of the population.

The group has begun to discuss other areas as well. One of the items that has been under discussion that represents some of the thinking of the internal group that has also been discussed inside CDC and by the STLT Think Tank regards what a health department might be thinking and might need to do. This pertains to how to make this real for health departments and not just an academic understanding of an issue. The following represents a decision tree type of thinking:

**Exploring Steps after Data: Connecting Determinants to Action**

This social determinant is a problem in my community (from CHSI)	and has an impact on these health conditions	and can be measured by this indicator (from CHSI)	and could be addressed by these evidence-based* intervention strategies	in Partnership with these types of organizations/agencies	with examples such as these
<i>For example</i>					
Access to healthy food	Diabetes, cardiovascular disease, others	Limited access to healthy food: Percent of population who are low-income and do not live close to a grocery store	School-based Programs Promoting Nutrition and Physical Activity	Public Schools; CBOs	Rural Community Works Together to Stay™, Fun and Fit™

\* Includes multiple levels of evidence

If a health department decides to address social determinants of health and identifies these in the community, they would want to know how it could be measured. For the first three columns in this example, the CHSI could do that by county and sometimes by zip code level depending upon the indicator. The last three columns are sparser in terms of what is available, but a health department would want to know what can be done to address problems identified in the community, including evidence-based and best/promising practices interventions, and with whom they should work. The idea is to figure out how to be practical for health departments so that they can begin to act upon what they learn about their communities.



Many challenges still lie ahead. Some of the questions the Think Tank developed and presented to the STLT Subcommittee include the following:

- ❑ Once a jurisdiction defines, measures and analyzes underlying SDOHs:
  - What is the role of the health department?
  - What is practical for a health department to take on?
  - What are the barriers to addressing SDOH and how can they be overcome?
  - Can health departments help “shine a light” on existing efforts to address SDOH?
  - How can CDC help?
  
- ❑ The group supports CHSI, considered where SDOH are already being addressed, and asked, “How can public health carve out or strengthen its role?”
  - Community benefit efforts (not-for-profit hospitals)
  - Built communities, partnerships with other agencies/organizations, et cetera currently not being evaluated for health impact
  - New healthcare funding models are being evaluated (e.g., ACOs, ACHs, SIM)
  - Disease-specific programs with a focus on social determinants of health
  
- ❑ How can we reach higher?
  - Breaking down barriers to HD engagement (e.g., legal, political, non-traditional partnerships, redefining the traditional role of PH, resources): What can CDC do?
  - Identifying CDC mechanisms that might routinely incorporate SDOH (e.g., FOAs, inclusion in guidances)
  - Expanding partnerships with non-health agencies at the federal level
  - Expanding partnership with non-health non-governmental organizations (NGOs)

### **Discussion Points**

Dr. Ross recently attended a meeting in Chicago of the Association of American Medical Colleges (AAMC) during which New York Presbyterian Hospital was recognized for a major award based on their ability to combine their community health assessment with the health department’s assessment, and engage in an outstanding community intervention project that is currently ongoing. They have a phenomenal amount of data, which is as granular as he has ever seen, that is driving that process. He plans to speak with them about their data acquisition and management, and thinks they should be highlighted as a best practice for incorporating social determinants of health, particularly with regard to interfacing with hospitals. Health departments that are undergoing accreditation have accumulated data, but the accreditation is voluntary.



In terms of CDC's role, Dr. Ro pointed out that there is a tremendous amount of purchased data from private entities that locals cannot collect (e.g., Google, Amazon, Walmart, et cetera). It would be great to see some of the opinion polling. NACCHO recently published a health equity brief that discusses Kentucky and its opinion polling, which is a great model for understanding how to influence policy. There are many new health care financing models (e.g., ACOs, ACHs, SIM), but she asked where the new population health funding model is. She is aware of the work being done in public health to assess the chart of accounts in getting to basic public health financing. However, the ACA has "sucked up all of the air" around healthcare and not around population or public health. There has been a downward spiral in terms of financing for public health and population health. There are not readily available data to demonstrate what the investment has been. Having only \$2.00 of flexible funds per capita to deal with healthy eating, active living, and tobacco is frightening.

Ms. Lipshutz replied that apart from this particular committee, her office has focused on trying to get health departments more engaged in some of those models. The SIM states will be awarded grants shortly, which will be a significant amount of funding. They are required to have a population health plan and to engage in public health. They will watch how that plays out very closely. There is also a discussion about what defines "population health" and whether it is the same as "public health." These issues are of great concern to CDC. OSTLTS and the policy office have been focused on this. It is critical that these new models do not become only healthcare. They are supposed to incorporate more prevention, and SIM states are supposed to be modeling population health in the mix of their models.

Dr. Botchwey said that she is interested in the barriers that exist. One example that may be helpful is the American Planning Association (APA), which recently received a \$3 million three-year cooperative agreement in which they will be a grantee to their member planning associations in cities. Those member planning associations are required to partner with local public health departments in order to receive those funds. Models may result from those partnerships that would help to reveal some approaches to overcoming use barriers, at least from the planning and public health side.

Dr. Williams reported that the next day, an Institute of Medicine (IOM) committee on which he served would be reporting on a final set of recommendation on social behavioral measures. The committee focused on those items that are actionable from a clinical perspective, as well as a population perspective. A number of organizations are engaged in innovative work such as Dr. Ross mentioned, but more are going to come on line soon to test this new set of measures to see how well they work over time. While he believes that it is only a matter of time before these become part of what everyone does, that may be 10 years from now.

Dr. Ross reported that Health Information Management and Systems (HIMS) is way ahead in terms of incorporating social determinants of health into patient health records (PHRs). That is great fodder for looking ahead, and he seconded Dr. Williams' support of looking at electronic medical records (EMRs).



Ms. Lipshutz said she is familiar with this work. It is focused on healthcare, so the question is: How does public health benefit from this work and how do we take advantage of it? That is a challenge that needs to be addressed in some fashion, and she invited any suggestions.

Dr. Richardson mentioned another organization on which she and Ms. Wilson serve for the Commission to End Health Care Disparities (CEHCD). One of its major initiatives is improving collection of patient-level race/ethnicity, language status, disability, gender/sexual identify status. One of the action items is working with electronic health record (EHR) vendors about making the way that those data elements are gathered in EHRs more useful, easier to pull out, and easier to stratify. EHRs, now called PHRs, may become the granular-level data sources, especially in terms of communicating across healthcare organizations, the Regional Health Information Organizations (RHIOs), and HEIs to pool all of these records together. There may then be some granular data available about individuals pertaining to behavioral and social determinant metrics and some of the characteristics that define disparities. It is going to take a while for roll out, and adoption of each level of “Meaningful Use” lags behind the time tables. It is worth monitoring and trying to guide and direct this process to make sure it is useful to public health and intersectoral efforts as well.

Dr. Ro noted that the National Committee on Vital and Health Statistics (NCVHS) has convened some sessions over the last couple of years to assess these issues, so they would be another good resource for OSTLTS.

Ms. Lipshutz indicated that John Auerbach, who initially chaired this committee for the OSTLTS subcommittee, is now working for CDC in the Office of the Associate Director for Policy (OADP). He is very involved in these issues and is thinking about them from the perspective of the new funding models and the healthcare perspective. She encouraged everyone to attend the evening’s reception to meet and talk with him.

Dr. Richardson reminded everyone that there is a CDC workgroup on public health/health care collaborations that is addressing a number of these issues. There are many opportunities for public health and the health sector to work together around shared goals, which will be highlighted in the recommendations report to be published.

As the tool becomes available, Dr. Botchwey asked whether the workgroup had given any thought to: 1) ways to provide training to health departments, schools of public health, and non-health academic departments so that this can become widely used; and 2) making recommendations to the Public Health Accreditation Board (PHAB) that this be used as a resource as health departments go through the voluntary accreditation process.

Ms. Lipshutz replied that the subgroup had not addressed the training recommendation at this point, but certainly would promote this type of work in that way. There is work in the PHAB area as well. They hope to push the tool out widely so that it can be refined and adjusted as necessary as soon as possible.



### **Collaboration with the STLT Subcommittee and Other Advisory Committees**

Dr. Richardson reminded everyone that one of the initiatives HDS identified regarded collaboration with the STLT Subcommittee. For about a year, HDS also has been contemplating how to work with advisory committees to other federal agencies to accelerate progress on health equity across all of the agencies. Some efforts seem to have occurred because some HDS members serve on other committees as well, but perhaps HDS can take a more strategic approach to make productive linkages with advisory committees or subcommittees of other federal agencies. There has been discussion regarding HDS presentations to other advisory committees. There was a conversation with the IOM Roundtable a number of years ago. Perhaps this is the time to follow up on that as well. An HDS workgroup was not established for this effort, given the sentiment that this could be a general committee discussion. Dr. Richardson requested additional comments/suggestions regarding collaborations with the STLT and other federal advisory committees/subcommittees.

### **Discussion Points**

Dr. Ro noted that because the Social Determinants Think Tank is working with them, an equity lens is being applied there. However, she emphasized the importance of ensuring that a health equity lens is also applied within the Public Health Surveillance and Public Health Finance Think Tanks.

Ms. Lipshutz replied that the Public Health Finance Think Tank has been functioning longer than the Public Health Surveillance Think Tank. The Public Health Finance Think Tank has focused on foundational capabilities in public health and how those will be paid for. The Preventive Health and Health Services (PHHS) Block Grants have moved to OSTLTS, so there was an opportunity to try to grow the transparency of how that funding is spent and try to help ensure that it is addressing some basic public health needs and safety net issues in communities. These are grants that are guided by a community process, so CDC has limited influence over the allocation of the funds. The committee has developed some guidance for these grants that relates to growing and supporting public health infrastructures. The idea is that public health departments are in a position to provide services to those who otherwise would not have them. While the focus has been on the block grants, there is now a focus on how foundational capabilities that every jurisdiction should have that are available to everyone will be paid for.

Dr. Ro indicated that she serves on her state's Technical Workgroup. Washington is one of the states that is moving forward rapidly in considering its model. It is very difficult to ensure that there is inclusion of the equity lens in that conversation. Even in terms of foundational capabilities, ultimately the question is: To whom, to do what, and where should services be directed? If the equity lens is not incorporated into the thinking and design of systems, it is very difficult to integrate it later.

Ms. Lipshutz indicated that the Public Health Finance Think Tank would welcome recommendations and HDS participation in its discussions if that would be helpful. The current chair of that group is Dr. Terry Cline, and David Fleming also serves on that group.

Dr. Richardson asked whether any metrics are attached to the block grants.



Ms. Lipshutz's understanding is that measures have not been attached to the block grants. Because these are now ACA-funded, there has to be more evaluation of how the funds are being spent. Metrics are being discussed and developed, but because every community makes its own decision about how the funding will be spent, it is not possible for CDC to measure one item across the country.

While it made sense to Dr. Richardson that these would be specific to the needs of individual communities, it might be possible to include a requirement that, regardless of how the community set it up, there has to be a health equity focus and indicators and targets. Communities could decide what the focus, target group(s), program(s), et cetera would be; however, they must build it in as part of the award. This is exactly the time to structure that in, because once it is set, people will do what they are being funded and held accountable for.

Ms. Lipshutz replied that she would pass this on to the Public Health Finance Think Tank during their next meeting, and emphasized that HDS interaction would be welcomed by that group as well.

Dr. Ro said she would be happy to join the conversation. It is difficult because the focus tends to be on services rather than health equity.

Dr. Richardson said this is exactly what it means to look at everything with an "equity lens." No matter what the work, thought must be given more broadly to the implications of groups who are subject to disparities regardless of the community and program.

Dr. Liburd clarified that the PHHS Block Grant funds state health departments. This has historically been a formula grant program, so the amount of funding that is allocated to each state is based on the size of the population. This has been described as a "flexible pot of money." Many states have used it to support infrastructure. Some historical commitments have been made across the states for certain activities. The process will now set forth some metrics and expectations. Each state has an advisory committee that is supposed to offer advice about the expenditure of these funds, so there would also have to be state level advisory committee buy-in regarding the desire to apply a "health equity" lens.

Dr. Richardson stressed that even though there can be local decisions about specific programs based on each state's circumstances, a health equity requirement should be built in to the funding structure. Sponsors have ways of building requirements into grants.

Given that this is a grant versus a cooperative agreement, Ms. Lipshutz was not sure how this would play out. However, it will be of great interest for the group to discuss. She indicated that the Public Health Surveillance Think Tank had met only once in person and conducted one teleconference thus far. They began focusing on the problem with the number of surveillance systems that are used by CDC, states, and local areas and how cumbersome these are. There is now a CDC surveillance strategy to try to address some of these issues. The Public Health Surveillance Think Tank began by using that as a basis to consider how to make this strategy more useful and helpful to states rather than simply focusing on CDC's multiple systems that



are burdening people. Every disease silo has its own requirements and states have to report to different entities in different ways. Another issue the Public Health Surveillance Think Tank is discussing regards how public health and healthcare interface in the evolving healthcare system. They are thinking about system level issues and the lack of resources health departments often have to work with, and the burden of creating these types of systems. They are still working at the conceptual level, and are not considering the details of what should and should not be included. Instead, they are discussing standardization of how information is requested and reported. There may be some place for the equity lens.

Dr. Richardson thought this was a similar example to embedding patient-level data into EHRs and healthcare systems. As data elements to be included in surveillance systems are standardized, it is important to ensure that sufficient data are collected to assess any condition across the potentially disadvantaged categories/groups rather than having no data on race/ethnicity, socioeconomic status (SES), disability status, gender identity status, et cetera.

Dr. Ross asked about the functionality of CDC's current surveillance systems in terms of collecting social determinants of health.

Ms. Lipshutz responded that the current systems do not collect social determinant health data, given that those data are not typically what any disease entity would collect. However, that may vary from program-to-program. There is no standard means by which data are collected.

Dr. Liburd added that the 2013 *CDC Health Disparities and Inequalities Report (CHDIR)* included 10 social determinants of health indicators. Once the health equity indicators are identified, a decision will need to be made about what to do with those. There is not an entity that is collecting social determinants of health data. The Behavioral Risk Factor Surveillance System (BRFSS) has a social context module, but it has only five or six questions. There was an effort within the Division of Population Health (DPH) to build a larger BRFSS module on social determinants of health. However, the person who directed that program at the time is no longer the director. Dr. Liburd does not know what occurred in the transition, but will follow up on the status of that module. The Community Health Status Indicators (CHSI) data has some social determinants of health.

Ms. Lipshutz indicated that the CHSI data are not CDC's data necessarily. They include CDC data, but the non-health data sources are not CDC's. They just access other databases for the same communities. That is not necessarily a bad thing, given that CDC cannot collect everything. However, CDC should be able to help access data.

Dr. Liburd noted that CDC uses the American Community Survey (ACS) data source to describe the social determinants on which CDC does report.

Dr. Penman-Aguilar added that NCHHSTP has some recommendations to include social determinants of health in all of their surveillance systems.



Mr. Vargas asked whether other advisory committees had been identified that address health disparities specifically, which could be a starting point. If so, all of the advisory committees with this focus need to know about each other's efforts and then determine whether they can all coordinate.

Dr. Ro replied that the HHS Advisory Committee on Minority Health has not met for most of 2014. They have just filled out their roster. Given that HHS now has a number of set recommendations, it would be beneficial to announce the priority areas to other committees. The workforce component is certainly an area of synergy, given that this has been a longstanding issue for the HHS Advisory Committee on Minority Health. A number of the other areas may be as well. Synergy in recommendations and engagement occurs when advisory committees at various levels call for similar recommendations in areas of focus. Highlighting what CDC is doing is a great way to make those linkages. She believes this can easily be done with the new HHS Advisory Committee on Minority Health, whom she knows well.

Dr. Williams pointed out that there are a number of new Offices of Minority Health that did not previously exist, but he did not have a good sense of which ones have advisory committees. Looking at people's titles earlier in the morning during the forum, he was struck by the number of people within CDC working on health equity and disparities. He wondered whether there was a CDC organization chart that depicts all of the disparities activities within the agency. It is important to understand what coordination is occurring within CDC, as well as what opportunities there are to expand these efforts outside of CDC. It would be interesting to know what the coordination of Associate Directors for Health Equity is within CDC, or whether that would be desirable if there is none. He would think that people working on the same thing within the same organization would have some degree of coordination and communication.

In terms of the reporting structure, Dr. Liburd indicated that CDC staff members with the title "Associate Director for Health Equity" report within their CIO. Even within CIOs, this differs. Donna McCree is in the Division of HIV/AIDS Prevention (DHAP) within NCHHSTP, and she reports to the Director of that division. Jo Valentine is in the Division of STD Prevention (DSTDP) within NCHHSTP, and she reports to the Director of that division. Wayne Duffus is the Associate Director for Health Equity at the center level of NCHHSTP, and he reports to the Director of the center. There are hard and soft lines. OMHHE sits in the Office of the Director (OD) of CDC, and does not have a hard line reporting structure to anyone outside of OMHHE. OMHHE does not coordinate with the Associate Directors for Health Equity, but does communicate with them. They are all part of the Health Equity Workgroup. "Voluntary" is not a good word, but she would have to find the right word to describe how they work together. She will generate an organizational chart. The forum certainly brings everyone together annually, and there are a number of events that bring them together. OMHHE has tried to be deliberate about bringing the Associate Directors for Health Equity together, but often it is just a matter of how many days in a week, how many hours in a day. It is harder to schedule a meeting than to get people into the forum. To bring them all together again, it would be necessary to begin now for a meeting in December. They are very open to working with OMHHE and to keeping Dr. Liburd abreast of efforts they are making inside and outside of the agency. OMHHE coordinates with them on everything. There are Offices of Minority Health within the Food and Drug Administration (FDA), Center for Medicare and Medicaid (CMS), Substance Abuse and



Mental Health Services Administration (SAMSHA), Health Resources Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and National Institute on Minority Health and Health Disparities (NIMHD).

Dr. Botchwey indicated that for the September conference call, a small group discussed federal agencies and created a list of contacts at each agency.

Dr. Ross added that the list included the IOM Roundtable on Promotion of Health Equity and Elimination of Health Disparities, IOM Roundtable on Population Health Improvement, the IOM Roundtable on Obesity Solutions, HHS Office of Minority Health Advisory Committee, CMS Office of Minority Affairs, Diversity and Health Equity Officers at SAMSHA, Diversity and Health Equity Officers at FDA, AHRQ, and two more. The goal was to develop an “ask.” What do we want those institutions to do? The plan was to develop three or four questions about the priorities of those organizations, the resources that they have to execute those priorities, and their shared interests. This effort is still in the nascent stages, and they thought it would be best to see what happens with Ruffin’s replacement at NIMHD.

Dr. Liburd reported that Dr. Maddox is serving as the Acting Director for NIMHD if they would like to speak with her. She was with Karen Anderson, the IOM Health Equity Round Table Lead, at the meeting in Chicago. She mentioned that the HDS had generated some recommendations, and she requested that Dr. Liburd share those with her. She also invited Dr. Liburd to attend the April 2015 meeting of the IOM Health Equity Round Table and present an update about the work that is coming out of CDC as well as the subcommittee.

Dr. Richardson expressed appreciation for the subgroup’s efforts in making the list of agencies to which the HDS should be reaching out. She was also attracted to Dr. Ro’s idea of sharing what the HDS has done. It is good to have some specific focus for whatever the communication and collaboration will be. However, she was not certain that they should start with an “ask” at this point. Perhaps they should go with a “gift” instead of an “ask.” They could describe the framework HDS has presented to CDC, explain the progress that they have begun to see on implementation, and indicate that HDS would like to start a conversation with other groups about how they are offering these initiatives in their agencies and find out whether other agencies have a set of recommendations to share with the HDS.

Dr. Ross found that to be much more pragmatic. He and Dr. Botchwey will work offline using the HDS recommendations to develop an introductory letter, email, or other mechanism.

Dr. Richardson thought this would be a good way to begin the outreach process and perhaps get some bidirectional conversations underway, which could possibly grow into a collective conversation at some point if they can broker some relationships.

Thinking about efficiency, Dr. Ro pointed out that the FOA language is a major step forward. Making sure that all agencies include that language is of great importance. Developing a health equity curriculum is also a major step, but there are already a number in existence. For instance, NACCHO has its own. These efforts begin to set goals and some momentum when everyone is engaged in some of the same types of work. Developing indicators is another



valuable piece of work, but hopefully these are not different for every agency. If CDC is in the forefront, other agencies can adopt CDC's indicators.

Dr. Richardson thought that getting some conversations going could perhaps progress to a series of conference calls on various topics (indicators, workforce, et cetera) in order to leverage everything that is available to move everyone forward.

Ms. Wilson asked whether the format would be different for the next CHSI report. In the last report, the data did not allow for drilling down by racial or ethnic group. The data are not very in-depth to begin with. Even though it is being updated, it was not clear to her how useful it would be.

Ms. Lipshutz replied that the updated report has been substantially improved and enhanced, and will soon be launched. It is an interactive, automated tool that will allow one to pull out different sets of data. She gave a demonstration at the end of the session.

### **Public Comment**

In terms of the implementation of the Healthcare Marketplace, Ms. Chanta Chambers, Patient Advocate Foundation, wondered whether there are any plans to assess disparities that may exist in terms of enrollment by race, gender, and/or geography. Regarding data that may not be collected now but may need to be collected in the future to define and tell the story, she stressed the importance of Marketplace design to increase access to healthcare. It is important to evaluate whether the disparity gap is being broadened, because individuals are selecting the wrong type of plan that does not properly link them to the access or degree of care that they need. The Patient Advocate Foundation is very interested in learning more about this, and is conducting a specialized survey of those who have contacted the Patient Advocate Foundation with an inquiry related to the Marketplace to see if they were successful in enrolling. Other organizations like the Patient Advocate Foundation may have that type of data available.

### **Discussion Points**

Ms. Wilson said that she is personally interested in and wanted to write about disparities that may exist in terms of enrollment by race, gender, and/or geography for a paper for a class she was conducting. However, she found those data very difficult to obtain. The Kaiser Family Foundation is publishing data, but getting the data by race/ethnicity and language is nearly impossible. Many of the state Exchanges are not even collecting data for race/ethnicity. She was conducting some cultural competency trainings for Connecticut, so she had some connections there. She spoke to some people from the Connecticut exchange who said that although there are race/ethnicity and language fields, they are not required. She could say anecdotally that they did not do as well as they should be. Maryland is about to begin open enrollment and the state site is up and allows browsing, but people cannot yet enroll. It is important to talk to communities to get people enrolled, and to specifically target those who were enrolled last year to make sure they re-enroll, to enroll more people, and to make sure that people select the correct plans. In terms of potentially broadening the disparity gap, not only is there the issue about health literacy, but also there is the issue of health insurance literacy. This is another language entirely. Add language access to that and consideration must be



given to whether it is at a level people can understand. Ms. Wilson offered to speak with Ms. Chambers further offline.

Dr. Richardson said she heard an interesting presentation recently about some work done regarding the understanding of the information needed to enroll in the Marketplace—even amongst educated, English-speaking people. Less than half understood terms like *deductible*, *co-payment*, *co-insurance*, et cetera. To their credit, the group that did this work submitted their findings to a Congressional committee. They were also trying to share their findings with another agency in the hope that their data about the kind of language and information people would need to knowledgeably use the website could be incorporated into the next enrollment cycle. She is also aware of some unpublished data, which should be released in the next few weeks, which show the health benefits for those who enroll.

Ms. Chambers suggested that perhaps it would be worth making some comparisons between non-Medicaid expansion states and those states that participated in expansion, especially for those who want to apply the health equity lens to the way the data are assessed. As HDS is thinking about policy, she requested that this be given consideration. Other organizations will also perceive this as a major issue moving forward.

Dr. Ro reported that anecdotally in Washington State, they are hearing that the free clinics are seeing many of the people who are under-insured or have the wrong insurance. They are also seeing those who remain uninsured and cannot get insurance. She has not heard of any surveys of free clinics to understand changes in their patient profiles, but this would be extremely interesting information to have.

### **Updates on HDS Priorities**

Dr. Richardson reminded everyone of the five activities identified by the HDS members as priorities to accomplish over the next year or so. An update was provided for each of these during this session:

#### **Funding Opportunity Announcement (FOA) Language**

*Workgroup Members:* Dr. Horner-Johnson, Mr. Vargas, Ms. Wilson

Ms. Wilson reported on the activities of the FOA Language Workgroup, which recently convened its first teleconference call. During that call, Mr. Dicient-Taillepierre provided a background of the CDC FOA announcement, guidance, template, and timeline. Ms. Wilson discussed SAMHSA's approach and their disparity impact statement (DIS), which is required as part their application for funding since 2013. As a result of that, the workgroup had a call on November 10<sup>th</sup> with Roslyn Holliday Moore, who is a Public Health Analyst in SAMHSA's Office of Behavioral Health Equity (OBHE). She reviewed SAMHSA's process for incorporating the DIS into their request for funding announcement (RFA). Though Mr. Dicient-Taillepierre prepared some notes, the workgroup has not reviewed them or had an opportunity to debrief yet since the call occurred so recently. The plan is to have a series of workgroup conference calls and then to follow-up with Ms. Moore.



SAMHSA is a smaller agency than CDC. While the workgroup members realize that there will be some challenges, they do believe that there are some lessons learned because health equity has already been incorporated into the SAMHSA RFA. A couple of the programs that presented the previous day indicated that they have incorporated health equity into their FOAs, but it is important to understand whether there is accountability and data are being reported. SAMHSA grantees have to submit data on their DISs, a centralized system is being rolled out, and their Project Officers are evaluating these data. For example, an applicant cannot state in an application that they plan to work with Spanish-speaking Latinos in Brooklyn but later indicate that they were unable to recruit any Spanish-Speaking Latinos in Brooklyn and are working with Russian-speaking immigrants instead. The workgroup will be considering such issues, but is still in the early stages of development at this point. Hopefully by the time of the next HDS meeting, they will have more to report. They also discussed sharing the SAMHSA RFA through the Federal Interagency Health Equity Team (FIHET).

Dr. Horner-Johnson added that the language that is currently in the CDC FOA is acceptable. It covers the basics; however, the workgroup would like to develop something with “more teeth” to it. SAMHSA’s example seems to be really good and is very comprehensive. It was not just about changing the RFA, it was about changing the organizational culture. It is not likely to be an easy process at CDC, but the workgroup believes some lessons can be applied from the SAMHSA effort. Mr. Vargas pointed out that this change came from the leadership at SAMHSA. The SAMHSA Administrator made the decision that required this in all of its RFAs. Having the leadership support such an effort from the top offered the leverage, ability, and the will to make this happen. Dr. Horner-Johnson noted that SAMHSA initially rolled the RFA out with four programs that really wanted to do this and have continued to be champions for it, which is also an important aspect of their effort.

### **Discussion Points**

Dr. Botchwey asked whether SAMHSA has any data on the impact of the incorporation of these guidelines.

Ms. Wilson responded that it has only been a year, so it is probably too early to tell. SAMHSA has linked health disparities with cultural competency and the Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. They are working to ensure that all of their Project Officers are well-trained in the CLAS Standards and how it is inextricably linked with health disparities, so that they are able to provide the best technical assistance possible. SAMHSA’s goal is to ensure that this effort is making a difference. Program-specific DIS samples are included on SAMHSA’s website for all of its RFAs. Not only do grantees have to submit the DIS statement with their applications, but also they have to submit periodic status updates to their Project Officers through the database, so these are measurable data. Also important to note is that although the process took SAMSHA only 6 months, Mr. Dicient-Taillepierre told the workgroup that it typically takes about 18 months to complete a process via CDC. Therefore, he suggested submitting something to HDS by May 2015 for approval.



In terms of the calendars for HDS and ACD, Dr. Richardson thought that if the HDS has something ready to recommend that could be submitted to the ACD during the April 2015 meeting. However, submitting something to the HDS in May would mean that it would not be submitted to the ACD until their October 2015 meeting at the earliest. She suggested attempting to develop a recommendation to present to the ACD in April 2015 if at all possible. The length of time it may take to implement a recommendation should not deter them from submitting it for approval as soon as possible.

### **Coordination of Information**

*Workgroup Members:* Ms. Ryder, Dr. Ross, Mr. Fukuzawa, Dr. Botchwey, Dr. Richardson

The Coordination of Information Workgroup was established to deal with coordination of information across agencies and the convening role that HDS could play in creating linkages across organizations such as IOM, the HHS Office of Minority Health, and other relevant groups throughout HHS and other federal agencies. There may be opportunities to join the advisory committee for OMH and to build a network of people who think about issues in diffuse ways. Sending some form of communication to identified parties agencies about HDS recommendations would be a good means by which to begin a conversation. Dr. Botchwey reported that the Coordination of Information Workgroup has engaged in a couple of teleconferences in which they developed a preliminary list of contacts and discussed the development of an email message to send to the various contacts regarding the HDS recommendations. The goal was to disseminate this email within two weeks following this meeting.

### **Discussion Points**

Dr. Ro suggested reaching out to chairs of other committees, send information, and perhaps arrange a phone call if they express interest in speaking further.

While she understood Dr. Ross's point about making contact with the highest offices for the greatest attention, Dr. Richardson pointed out that sometimes things move faster if an effort is made informally among chairs versus through a formal process. That would at least get a conversation started. At some point, it could then evolve into a specific recommendation that could be made formal and submitted to the ACD.

Dr. Liburd emphasized the importance of letting the recipients of the emails know what to do with the information and what they are trying to leverage.

Dr. Ro added that it is important to let other advisory committees know that the HDS is interested in alignment with other committees. Other committees may be interested in inviting the HDS chair or other members to attend their meetings to discuss particular issues and vice versa.



Dr. Richardson agreed that some specific next steps should be suggested in the initial correspondence, but these should be relatively low-burden. Sharing what the HDS has done, indicating an interest in knowing what others are doing, discussing the desire to align, and suggesting a call would be a good goal at this point.

Dr. Ro suggested speaking further about the coordination amongst the CIOs at CDC. The previous day, HDS members had a wonderful opportunity to meet and hear from many of the agency's representatives who also are focused on minority health and health equity. Given that HDS has a set of recommendations, one opportunity would be to know when there are new initiatives or advisory committees for the various centers publishing substantial recommendations. Perhaps these all flow through the ACD. The degree to which the health equity lens can be universally applied throughout CDC is a major hope of the HDS.

Dr. Liburd indicated that OMHHE could reach out to MASO, which is the office that coordinates all FACA-chartered committees to obtain a list of CDC's FACA-chartered committees. Several programs within CDC have committees that assist with clinical guidelines and so forth.

Using an example from emergency preparedness in King County, Dr. Ro indicated that they assessed potential activation in terms of Ebola. Their emergency activation team includes an individual on that team whose sole purpose is to assess the work that is occurring through a health equity lens. While that is not an advisory committee, she raised this as an example of the way health equity is incorporated through the activities of an agency. This is done in part because King County's communities are so diverse. This pertains not just to what happens, but involves communication to the community as well. With Ebola, there is a lot of concern about stigmatization not only of West Africans or African immigrants, but also the potential spillover effect for all African Americans and blacks in that region. They have heard of some individual anecdotal instances in which people have been denied service by hotels. From an equity lens, these are the type of issues to monitor overall.

Mr. Vargas emphasized the importance of the goal of coordination of the health equity lens throughout CDC's CIOs. It is vital to reach out to other FACA-chartered committees within the agency as peers to let them know that HDS's priorities have been adopted by the ACD and that the HDS is a resource to other committees that want to do this as well.

Dr. Liburd will forward the list of FACA-chartered committees to Drs. Botchwey and Ross to determine which are relevant.

Dr. Botchwey indicated that in addition to the MASO list, she and Dr. Ross will go through the Federal Interagency Health Equity Team (FIHET) membership list to ensure they have complete contact information for relevant subcommittees from there as well.

Dr. Richardson pointed out that the communication would probably be slightly different to outside versus inside committees.



## **Training and Composition of the Public Health Workforce**

*Workgroup Members:* Dr. Ross, Mr. Vargas, Ms. Wilson, Dr. Ro

Dr. Ross reported that CDC's Coordinating Council on Diversity in Public Health was tasked with creating a report on training and composition of the public health workforce for the HDS. At the request of Congresswoman Barbara Lee, then Chair of the Congressional Black Caucus (CBC), CDC Director Thomas Frieden hosted a Medical College Roundtable on May 23-24, 2010 to foster greater collaboration on health disparities and related workforce development issues. Participants included representatives from medical schools of Historically Black Colleges and Universities (HBCU), as well as medical colleges and universities that graduate the largest number of students who identify as Hispanic, African American, American Indian/Alaska Native, Asian American, Native Hawaiian, and other Pacific Islanders. Participants discussed specific actions to eliminate and reduce health disparities, including ways to increase minority representation in public health professions and as students at medical colleges. The participants decided to continue to meet as a group and became the Coordinating Council for Diversity in Public Health. The council is co-chaired by Dr. Ross, with Dr. Leandris Liburd and Dr. George Roberts. While the council is a CDC entity that provides input to CDC, it is not a formal CDC committee.

The Coordinating Council for Diversity in Public Health's vision is improving health equity through the preparation of a diverse, culturally competent public health workforce. Its mission is to accelerate the achievement of health equity through enhanced public health training in schools of medicine and the development of a diverse public health workforce. The council's goal is to collaborate with key public health and medical school partners to leverage strategies that result in more schools of medicine offering courses and degrees in public health, greater exposure of medical students to the practice of public health, including at CDC, and greater racial and ethnic diversity in the field of public health research and practice. The council's agenda includes advocating for increased competency-based public health pedagogy in schools of medicine as well as social determinants approaches in schools of public health; expanding public health service opportunities for all public health students; and establishing a robust process for evaluating teaching and experiences with public health allies. The council is comprised of the following members:

- Will Ross, MD, MPH: (Co Chair) Associate Dean for Diversity, Professor of Medicine Washington University/School of Medicine
- Harrison Spencer, MD, MPH, DTM&H: President and CEO, Association of Schools and Programs of Public Health
- Marc Nivet, EdD: Chief Diversity Officer, Association of American Medical Colleges
- Maria Garcia, MD, MPH: Hispanic Serving Health Professions Schools
- Edward Tepporn, Executive Vice President: Asian & Pacific Islander American Health Forum (APIAHF)
- Terry L. Dwelle, MD, MPHTM: State Health Officer, North Dakota Department of Health



- ❑ Lois D. Banks, DMin: TRAIN Director, Public Health Foundation
- ❑ Dr. Swannie Jett, PhD: Executive Director, National Association of County and City Health Officials (NACCHO)
- ❑ Joan Reede, MD: Dean for Diversity and Community Partnerships, Harvard University School of Medicine
- ❑ Leandris C. Liburd, PhD, MPH: Director, Office of Minority Health and Health Equity
- ❑ George W. Roberts, PhD: (Co-Chair), Senior Advisor, Centers for Disease Control and Prevention
- ❑ Sheree Marshall Williams, PhD, MSc: Health Scientist, Office of Minority Health and Health Equity
- ❑ Julio Dicient-Taillepierre, MS: Team Leader, Initiatives and Partnerships Unit, Office of Minority Health and Health Equity

The October 17, 2014 teleconference meeting of the Coordinating Council for Diversity in Public Health's was very well-attended, with 11 of 14 members participating in the call. Dr. Ross charged the members to review the council's mission and vision, as well as the practices at their respective institutions, and provide input on what their institutions could offer to the council. The common themes that emerged from that extensive discussion are as follows:

- ❑ Coordinate opportunities for networking and mentoring of undergraduates interested in public health along with trainees in public health and medicine: have a booth at Student National Medical Association (SNMA) and American Public Health Association meetings.
- ❑ Create registry of practice and research opportunities in public health for students interested in careers in public health.
- ❑ Sponsor a national forum to address the need to improve diversity in the public health workforce.
- ❑ Develop a database of medical schools that provide public health education, along with documentation of the current public health workforce, stratified by race, ethnicity and gender.



## **Discussion Points**

Dr. Botchwey asked to what degree the council is currently able to represent sexual orientation and disability perspectives, given that she did not see that representation based upon the membership list.

Dr. Ross replied that sexual orientation and disability have been part of the conversation, but there should be formal representation. Obviously, these issues need to be expanded in the curriculum, which relates to the cultural competence skill set. They will identify someone for those efforts, and he invited recommendations for those representatives.

Mr. Vargas said he would be happy to talk with Dr. Ross and think about who might be a good representative. There is a similar scope issue regarding the focus on schools of medicine. There are nurses and other providers in public health, and he wondered whether they are part of the scope as well.

Dr. Ross replied that invitations were sent to the Association of American Nurses and others, but they did not get the response anticipated. That is in the “parking lot.” Initially, they were trying to assemble the council to start the conversation.

Dr. Horner-Johnson indicated that someone wrote a report a few years ago on inclusion of disability in public health curricula, which she offered to look up upon returning to her office.

Dr. Ross recognized the importance of disability and LGBTs, and a lot of activities are ongoing. The goal is not to centralize this and place a responsibility within CDC, but rather is to coordinate the process to CDC with input on some of these efforts and to align allies across the country. There are phenomenal ongoing efforts, and CDC does not have the capacity to expand and develop these types of fairly extensive programs.

Dr. Liburd reminded everyone that one of the goals for the CUPS program is for CUPS alumni who are interested and eligible to apply for the PHAP program. This year’s PHAP cohort includes three former CUPS students. The PHAP program receives approximately 6000 to 7000 applications for about 160 slots, so it is a major accomplishment to have three of the CUPS students accepted this year.

Dr. Ross emphasized how impressive it is to have approximately 7000 young people who have this interest. However, it is not possible to accommodate them. If they are not exposed, they will be exposed to biomedical research and clinical translation research, and the opportunity will be lost to provide a forum to capture and retain their attention. This is a matter of coordinating programs across the country and finding ways to increase the capacity of the PHAP and other similar programs.

Ms. Wilson asked whether these students are already undergraduates. The Sullivan Alliance to Transform America’s Health Professions emphasizes the importance of reaching students when they are much younger. When most people think of the health professions, public health does not come up at all. Everyone is thinking about wanting to be a doctor, nurse, pharmacist,



radiologist, social worker, et cetera. She emphasized the importance of reaching younger students to let them know about opportunities in public health.

Dr. Ro said it was nice to see such a great group of people assembled for council. Regarding the registry, the Commonwealth Fund used to publish an annual directory of minority health fellowships. While she did not know whether they still do this, it would be good to double-check. There used to be a pamphlet to distribute to those interested in fellowships, internships, or scholarships. That was a helpful document.

Dr. Ross confirmed that the Commonwealth Fund still provides that, but it is not comprehensive. That would be just one of the many inputs into the registry.

Dr. Ro said she thought that naturally in public health, the discussion is about public health and medicine and public health and healthcare. With respect to working upstream and addressing social determinants of health, a good point to make to schools of medicine and schools of public health is that it is also important to consider law, education, urban planning, and other fields. On the population health side, non-medical public health providers are lacking the skills to interact with different sectors. It is important to spend time on the diversification of the healthcare and public health workforce from the traditional public health and medicine perspectives, but a paradigm shift is needed to successfully figure out how to get to health in all policies or work with the education sector and labor. Policy, systems, and environmental change will require people training in law and public policy because it is a different frame of thinking. Partnerships are desperately needed with them in order to change environments. There is a role for medicine and traditional public health, but it is important to push further.

Dr. Ross replied that through an organic process, the council hopes to achieve that. He alluded to the charge to restructure the pedagogy in schools of public health to include social determinants. That is done by having a broader interdisciplinary discussion in schools of public health aligned with schools of business, law, and social work. The Washington University public health program is situated within the social work program and interfaces nicely with the schools of business and law. Having that broader organic discussion is beyond the current scope of this council; however, they will ultimately get to that larger discussion.

Dr. Botchwey indicated that there are efforts underway by the committee that is assessing the future of public health education. One of the subcommittee chairs and others are considering the issue of educating not only public health students on the non-health sectors, but also providing resources to non-health academic programs across the country on the key critical components of public health that will allow them to have shared language and shared experience. One of the critical components in the future of public health recommendations being presented in two to three months is a capstone course for public health students, which is required to some degree to incorporate non-health sector components.



Dr. Ro pointed out that Columbia University and other institutions have recently made significant investments in diversifying their faculties. It is known that if students do not see faculty of color who can help support them in their career (e.g., in networking, connecting, support after finishing school), the progress desired will not be made. She suggested looking more broadly at academia in general to identify models that can support that same momentum everywhere else, so that other universities follow suit with the same types of investment Columbia University and other universities are making.

Dr. Ross replied that he would present the comments regarding expanded pedagogy addressing non-health issues in schools of public health and schools of medicine through a competency-based curriculum.

Dr. Botchwey indicated that the Built Environment and Public Health Clearinghouse (BEPHC) has modules, curricula, and a host of other resources that can translate to public health and the non-health sectors. CDC, HHS, American Planning Association (APA), APHA, and the National Network of Public Health Institutes (NNPHI) are all partners on that project.

Dr. Ro reported that the Bureau of Labor Statistics (BLS) collects data on the public health workforce in general. ASTHO is currently collecting comprehensive data on the workforces of state health departments in large cities. This is done by survey, which people can opt out of, but participation is expected to be good. Administration of that survey began in mid-October, so preliminary data should be out in several months. The survey is known as Public Health Workforce Interests and Needs Survey (PH WINS), and it is funded by the deBeaumont Foundation. Further information is available at <http://www.astho.org/phwins/>

Dr. Richardson requested that Dr. Ross expand on what they have in mind in terms of the national forum and whether that was a meeting, organization, one-time effort, ongoing effort, et cetera.

Dr. Ross replied that it could be a meeting, or a component in a meeting of APHA with a dedicated focus on workforce diversity, bringing in thought leaders from across the country. It would be a very well-constructed academic forum to galvanize the community about public health workforce diversity. They have not fleshed this out enough to be able to say whether it would be an ongoing activity.

Dr. Richardson thought this would be a very important activity, perhaps at multiple organizations to get the conversation going. While this is a high-level national effort, perhaps the output could help guide the work going forward. To try to imbed the diversity issue in lots of places and in many ongoing activities would be beneficial. She suggested approaching the group focused on the future of public health education that has issued a number of reports, though she did not know to what extent they have covered the issue of diversity. Perhaps it would be beneficial to approach them to get a stronger statement or position from them. APHA is great, but perhaps there should also be something at AAMC, the national meeting of urban planners, and every other sector of interest to try to get this conversation started in each one of them.



Dr. Botchwey thought that some fantastic lessons could be learned from private industry as well. Coca Cola's diversity work is an example that started because about six years ago, their president said in an interview that by 2050, 50% of their managers will be women. At that point, only about 6% to 7% were women. Regarding diversity as it relates to women, Coca Cola has made substantial strides to reach close to 30% at this point. They have very strategic methods for reviewing, promoting, and training women to make sure that they reach the 50% goal by 2050.

Dr. Richardson asked whether OMHHE has assessed the public health workforce data for CDC in a way that ASTHO is doing with the PH WINS survey. It seems with the ASTHO data and federal workforce data, they would have a good picture of the public side of the public health workforce.

Dr. Liburd responded that OMHHE has data for CDC, but not for the federal workforce. However, they could probably access federal workforce data through HHS.

Dr. Ro suggested focusing on what happens within the scope of what CDC can control. Certainly, putting this diversity work in to practice through FOAs is an example. Perhaps they could also assess all of the advisory committees that inform the work of CDC to determine how diverse they are. HDS has race and ethnicity, but needs to add expertise in other areas as well. There needs to be succession planning for when current members cycle off in terms of the expertise needed. This does not have to be just one person from any perspective.

Dr. Richardson thought that it would be possible to add members to this committee, given that it is not fully populated. She invited suggestions for additional areas of expertise that members thought should be added.

Regarding the diversity OMHHE has sought to achieve with HDS, Dr. Liburd emphasized that diversity is comprised of much more than race and ethnicity. The goal was to include members with expertise in disabilities, LGBTs, rural areas, philanthropy, local public health professionals, national organizations, et cetera. She noted Dr. Richardson's statement the day before about partnering with emergency departments in terms of health equity work, which she described as "radical." In the formation of the committee, it is also necessary to be consistent with the federal guidelines and follow the rules for addition/approval of members.

Dr. Ro noted that there is a lot of discussion about education being so essential. For women in particular, it is critical to get females into STEM. For children of color to become public health professionals, it is imperative to reach them earlier so that they see models. There are some traditional ways to work with public health and education. However, there must be greater alignment at some point. While HDS is not meant to solve or necessarily tackle all issues, it is important to keep moving in that direction.

Dr. Richardson thought there was strong interest among the HDS members in the council, and she thought they stood ready to assist the council in pursuit of its very important objectives. HDS members will provide some specific suggestions to Dr. Ross about potential members with a focus on disabilities and on LGBTs. As this unfolds, she asked Dr. Ross to reach out to the



HDS with ideas about other ways this committee can be helpful to the council. This is separate from his role as a member of HDS, but it very much addresses Recommendation 6.

### **Recommendations Related to the CHDIR**

*Workgroup Members:* Dr. Horner-Johnson, Mr. Fukuzawa, Dr. Richardson

Dr. Penman-Aguliar reported that she and Dr. Liburd have been having a number of very good discussions with people across the agency. This report requires participation of all most all units at CDC. There have been extensive discussions regarding format, and one of the main concerns is that the communications aspects of the report still have some room for growth. The report is not necessarily in the format that everyone would prefer. Therefore, various options are under consideration. One option is a full report similar to the current version. Another option would be have the data presented biannually, with a brief summary of some of the indicators and a longer narrative on a few key focal topics. The same topic could be addressed every two years, but focus would change for each report. Another option is a format such as the one used for Health United States, which has a pullout section each year. An additional option is Vitalsigns™, which has an incredible communication infrastructure behind it. For example, there is a time schedule for Hispanic/Latino populations for about 20 products that are designed to penetrate very well. How a large report such as *CHDIR* could be funneled into a mechanism that is currently designed to give one or two overriding health communication messages remains unclear. However, those who run Vitalsigns™ say there is a lot of room for innovation. That certainly would meet the communications need. At this point, the options under consideration are for 2016. The topics would include an expanded focus on social determinants of health, expanding the dimensions on which disparities are examined, intersectionality, and attention to subpopulations. There will be a meeting with partners in January 2015. By the April 2015 HDS meeting, there should be more definitive options and formats.

### **Discussion Points**

Responding to a question from Dr. Ro, Dr. Penman-Aguliar confirmed that nativity is one of the dimensions.

Dr. Richardson recalled hearing the previous day about an effort underway within a multi-CIO workgroup focused on the issue of equity indicators. They are conducting a scan of existing indicators and data sources. She wondered whether these two efforts are linked.

Dr Liburd responded that they are.

Dr. Richardson asked whether data sources which were not included in the 2013 report will be available for the next version based on the expansion of programmatic activities. She also reminded everyone that one of the initial suggestions was for a more interactive web-based product as opposed to a status report.

Dr. Penman-Aguilar replied that they would probably rely on existing data sources, just in a different way. In terms of the non-health data sources, there is room for expansion.



Consideration is being given to an interactive web-format. One important aspect of that is to ensure that the data are interpretable and contextualized.

Dr. Horner-Johnson thought that would work particularly well for intersectionality if people can choose how they want the data stratified.

Ms. Wilson asked if Dr. Penman-Aguilar could share some examples of the types of subpopulations that might be investigated.

Dr. Penman-Aguilar replied that one of the recommendations of this report was to incorporate various dimensions for LGBT, disability, and subpopulations of racial/ethnic minority populations.

Dr. Richardson presumed that the limitations will be based upon the granularity of the existing datasets.

Ms. Wilson recalled Dr. Liburd's point earlier about geographic disparities in terms of rural, urban, and suburban populations.

Dr. Ross asked what audience the website would be intended to draw in (e.g., public health experts, CDC, institutions, et cetera). If the site will be accessed by the general community, it will need to point to another website that has a more condensed, user-friendly version of the information.

Dr. Penman-Aguilar would like to develop a communications strategy to make it as scientifically-based as possible. Her first thought about the target audience is that it would be state, local, tribal, and territorial health departments; community organizations; and academicians. They want it to be very broad. One of the beauties of the Vitalsigns™ strategy is that they have segmented their audiences so fact sheets and other materials are quite user-friendly. They have carefully thought through health literacy and accessibility so that there are no barriers.

Mr. Vargas asked about subpopulations, including LGBT and the limitations of the data, and whether CDC has a specific plan for inclusion of LGBT populations. There are surveys that collect data on orientation and gender identity. That is a larger questions than just the report itself.

Dr. Liburd replied that CDC's National Center for Health Statistics (NCHS) is charged with that data collection. OMHHE participated in the discussions about data and inclusion of LGBT data.

Dr. Penman-Aguilar indicated that the Health Equity Workgroup had an update from NCHS in which they discussed how they are implementing Section 4302. She thought NCHS would welcome the opportunity to talk to HDS about those efforts.



Dr. Horner-Johnson noted that another example regarding audience and format is the AHRQ health disparities reports. While these are still fairly technical, they use more graphics than tables and have nice bullet-pointed executive summaries. It seems like these might work for a somewhat broader audience.

Dr. Ro asked about plans to make this report visible within CDC to the different CIOs and to the degree that they are aware of the data and understand the data.

Dr. Penman-Aguilar responded that they are in close contact with the leadership of the CIOs. One of the mechanisms for that is the *Program Response MMWR*. They are polling CIOs about what they are doing about disparities in their categorical areas. At this point, the task is to gather examples of interventions and encourage the development of interventions where they do not exist.

Dr. Liburd pointed out that the data are coming from those programs, so they know what the disparities are. Whether the agency is seeking to understand disparities across all topic areas is a different question.

Dr. Richardson stressed that how the report is organized and presented depends upon the target audience. Her bias as a quantitative researcher is that she would like the data in as pure a form as is accessible so that she can “slice it and dice it” any way she wants. However, she believes that there is a broader audience who would want the data to be synthesized, interpreted, and presented to them. She recalled that in a previous discussion, the possibility was mentioned of perhaps identifying a topic on some regular basis that would be elevated out of the report. Perhaps this is the link to Vitalsigns™. Over the course of two to three years, it would be possible to go through most of the topics in the report to present it in a different way to a broader audience. It will be difficult to do everything all in one document. The AHRQ disparities report is a nice example, but even then she feels like there is compromise because they do not give her the data in the way she wants it, and it is probably too dense for the average lay person. Perhaps it is about a comprehensive communication strategy to present the data in different ways, to different audiences, through different vehicles.

Dr. Ro suggested that Dr. Liburd could pick a factoid from the report to highlight in the email blog that she sends out.

Dr. Liburd replied that OSTLTS has two resources called “Did You Know?” and “Have You Heard?” OMHHE has submitted two or three “Did You Know?” and a couple of “Have You Heard?” related to this data. There will be a more expanded discussion about particular strategies or programs.

Dr. Liburd uses data from this report and from the CDC website for different programs to frame the blog discussion.

In terms of interactivity, Dr. Horner-Johnson noted that there is an online disability data tool that allows for stratification of data in a variety of ways, but it is somewhat cumbersome to work with.



Dr. Ro expressed her hope that they are working with the BRFSS folks on this, because they are developing interactive data systems.

Dr. Horner-Johnson indicated that they are working with BRFSS and offered to share contact information.

### **Prevention in Public Health Fund (PPHF)**

*Workgroup Members:* Ms. Ryder, Mr. Pestronk

Ms. Ryder reported on the work that she and Mr. Pestronk have done, with some support from Dr. Liburd. The charge of this workgroup was to make recommendations for expenditure of funds in the PPHF. This was part of the Consolidated Appropriations Act of 2014 (HR 3547) by which Congress directed HHS to provide information on activities and programs supported with resources from this fund. Ms. Ryder and Mr. Pestronk decided that the best way to proceed with making recommendations regarding how these funds should be expended using the disparities lens was to take a historic look to identify how these funds have been allocated and expended previously. Reviewing the information available on the PPHF website, there was no easy way to discern what had been allocated to reduction of disparities. There were a few allocations that were clearly focused on disparities, such as the Racial and Ethnic Approaches to Community Health (REACH) grants. Approximately 740 awards were allocated through CDC and SAMHSA for issues such as Alzheimer's, healthcare-associated infections (HAIs), infectious diseases, heart disease, stroke, et cetera. There was no way to discern which of those funds have been historically spent to reduce disparities.

They conferred with Dr. Liburd, who mobilized some internal resources to investigate further than was possible on the PPHF website. There really is no demarcation. There is no disparities report card on the PPHF. Several options were considered to obtain that information. One was an informal request that might be sent to all of the CIOs to ask how those awards have been made, because each individual award would specify the focus of the allocation. However, they were concerned that they would receive a mish-mash of information in response to such a request due to the potential for different interpretations and different ways of gathering data. Consideration was also given to using the formal route of requesting that information through the Freedom of Information Act (FOIA), but that too had pitfalls and would not necessarily have provided the information needed. They have settled on asking Dr. Liburd, on behalf of HDS, to make a recommendation to the ACD that they begin to communicate in a proactive way about the importance of gathering these data moving forward, as funds are allocated to ensure this is an internal educational process to bring disparities issues to the forefront, in as positive and proactive a way as possible.



## **Discussion Points**

Dr. Liburd indicated that she agreed to have a meeting with the Office of the Director about how this data might be collected moving forward to understand how these funds are being used to address disparities.

In an effort to determine how big an “ask” this is, Dr. Richardson inquired as to whether there is any current reporting framework for these funds in terms of whether this would involve adding equity into something ongoing or if it would be asking for a tracking system that does not currently exist.

Dr. Liburd replied that it is not clear how big of an “ask” it would be, which is why more information is needed. While there are HHS reporting requirements, beyond this the information is unclear.

Ms. Ryder clarified that on the PPHF website, there are reports dating back to Fiscal Year (FY) 2012 that indicate by CIO how these funds have been allocated. What is not clear is how to drill down any deeper than that into the actual awards that are made to states and entities. There are also reports of planned allocations. Again, they have not been assembled looking through the equity or disparities lens.

Dr. Ross asked who the true Congressional allies/watchdogs might be in this effort with whom HDS could coordinate. This is a very political process and there have been miscreants on both sides of the aisle tapping into the fund.

Ms. Ryder replied that while she did not know the answer to potential Congressional allies, the feeling she and Mr. Pestronk had was that before they starting going over heads, perhaps they should look internally and try to call attention to this oversight and try to take care of it internally. That is totally up to the will of the committee, but their feeling was that they would do more good by pointing out the omission internally first and then trying to rectify the situation.

Dr. Ro was struck with the question regarding what counts and what does not count in terms of money or resources allocated to disparities, and she worries that it is a big “ask.” At the state level, trying to cost out public health services and the data that are collected to make an estimate, the data are messy. In the past, NIH has sometimes done this by assessing grants to investigators of color or for certain populations. It might be worth more discussion, because she would not want a request to be made that nobody knows what to do with, or for which HDS receives a response and does not know what to do with it because they do not know if it is good or bad.

Ms. Ryder emphasized that it was exactly their response, that they might receive a messy mish-mash of responses that are meaningless because people answered the question in unique ways. Not only is it a big “ask,” but also it is a very complex one.



Dr. Liburd clarified that there would not be a request for what has occurred in the past. Instead, it would be about how programs might pay more attention to their expenditures in the future in terms of health disparities.

Ms. Ro recalled that during the previous day's conversation, a medical epidemiologist kept asking the question about what outcomes are being achieved in terms of decreasing the disparity gap versus just improving the health of a vulnerable population. Those are different questions. That is why it is not clear what they are asking in terms of the question, "What resources or funds are going to address disparities?"

Ms. Ryder said she thought the question was clearly, "What money is going to reduce racial and ethnic disparities?" Part of the answer has to do with the extent to which an effort is simply aimed at trying to reduce Alzheimer's or breast cancer across all populations, versus the extent to which specific groups or subgroups are being targeted to assess current disparities as reported in Healthy People 2020 and begin to change those numbers.

Dr. Richardson suggested that one way to define this might be to ask about culturally-tailored programs that are designed for vulnerable populations. Recalling when this originally came up during the HDS's priority-setting mode, there was a lot of concern about what was happening with the PPHF, the cuts, and certain programs. It is important to think through HDS's objectives in terms of whether it is important to focus on this particular pot of money in this way or whether they should refocus on the broader issue across the agency (e.g., equity metrics). To some extent, trying to trace particular dollars that come from a particular source may create a great deal more work than a general reporting on disparities programming and equity progress. Attempting to trace particular dollars may add significant complexity to what they might be asking for.

Ms. Ryder replied that from her personal perspective, this is just one example of why it is important to focus on the equity lens across the organization. She and Mr. Pestronk saw this as an educational opportunity and felt that it was more important to look proactively rather than retrospectively. She ventured a guess that looking proactively across CDC and across CIOs would result in some education along with the message about why it is an important document and substantiate the work so that there is buy-in. As a federally-funded organization, the National Center for Farmworker Health receives calls from Project Officers requesting immediate information. When Congressional inquiries come through, it is important to know what is being done in terms of HIV for minority populations. They do not usually know why the questions are being asked or what they want to know. They may receive a simple three sentence request to respond to, and they have no way of knowing the importance. HIV may not have even been in their workplan. In order to avoid that type of "knee-jerk" reflex within the CIOs or at the grantee level, it would be much better to view this as an enlightening experience and one that deserves as much consideration as the public health workforce in terms of how to change these numbers. Health People 2020 has been monitoring the numbers for 30 years, and it is not clear whether there has been a specific plan or approach to try to change the relationship of those numbers. That is what this all about, which Ms. Ryder views as a full forward opportunity—not just a partial response.



As part of that forward-looking opportunity, Dr. Ro recalled that the State of Health Equity Forum would next focus on infrastructure, while the one after that would focus on policies. If this is made to be part of the work HDS is doing and as part of the next State of Health Equity Forum, that might help to couch it. There is nothing wrong with just asking the direct question, but if there is a direction and larger vision, it will help to move forward because there will be an understanding about why the data are being requested and what will be done with it.

It seemed to Dr. Richardson that idea of some kind of frame for prospectively tracking and reporting on equity work is imbedded in the HDS recommendations and is rolling out as part of the larger process. She wanted to make sure she was not missing the value of focusing on these particular funds and trying to separate that out. It may be easier to implement something across the board than to try to drill down just on the PPHF that come into various quantities in various CIOs. They may actually be distracting from what the HDS wants to get done.

Ms. Ryder replied that she and Mr. Pestronk discussed this, and she believed they would support looking to the greater good. Funds come and go and this one may not be here forever. Personally, she would recommend assessing the bigger issue. Ultimately, the decision is up to the HDS to make a recommendation about this.

Dr. Ross said he is a believer in applying the health equity lens across HHS for the greater good. Nonetheless, this funding had specific goals when it was conceptualized. Among those goals was enhancing public health workforce diversity, which is aligned with the HDS's recommendations. There are other goals as well, so he believes the HDS has a vested interest in how the funds are disbursed, but thinks they have to be cautious in how they present their concerns. He does not want to have a brushstroke, but he does believe it is within their purview to determine who is overseeing whether these funds are targeted to the areas initially specified.

Dr. Botchwey thought it would be helpful to get some perspective from Sherri Berger, CDC's Chief Operating Officer (COO). Money is input into what the results should be on the other end. She wants to make sure that as HDS continues this conversation, they line up the outputs/products with the input questions that they have a conversation with Ms. Berger about. Secondly, consideration should be given to whether HDS really needs to assess the inputs or if they should spend their energy on outputs.

Dr. Richardson said this was the way she was thinking about this, because tracing dollars through the flow can be very time-consuming. She thinks HDS is really interested in determining whether the outcomes that were specified in the ACA for those funds are actually occurring, and prospectively tracking those funds without approaching it as "You got X amount of dollars of this PPHD. Show us the programs et cetera that those dollars went to."

Dr. Ro asked whether Ms. Ryder and Mr. Pestronk spoke with anyone from the Trust for America's Health (TFAH). She explained that TFAH is one of the organizations that has been actively working on the PPHF. It would be good to have a quick conversation with them to find out what tracking they have been doing with their PPHF dollars. They are tracking whether funding has actually been allocated and makes it all the way through Congress. That is the



PPHF question versus the CDC question, but on the PPHF question it would be good to have a conversation with TFAH.

Ms. Ryder responded that they have not spoken with anyone from TFAH. They would be happy to do so, but would need assistance in determining who the proper contact person would be. Dr. Ro indicated that Dr. Jeffrey Levi is the Executive Director.

Dr. Richardson asked for a sense from committee about how to move forward with this in terms of whether to pursue a specific recommendation about PPHF per se or to ask a more general question about tracking disparity and equity outcomes.

Dr. Botchwey thought they should be cautious in how they engage in this issue, given that they do not know what types of landmines may exist. Ms. Berger may be a good person to engage in a short conversation with for guidance about this. She stressed that she was not encouraging them not to pursue this, but thought they needed to better understand the bigger landscape.

Dr. Horner-Johnson thought it was worth pursuing those two leads further in order to learn more, but thought it was also worth looking at what actually happens on the far end rather than trying to figure out the inputs.

Dr. Ross supported trying to assess whether the broader objectives of the PPHF have been met in terms of trying to discern whether the health equity lens has been applied.

Dr. Richardson said maybe it is about ensuring that all of those things that were the intended purpose of the PPHF are included in equity metrics that will get tracked going forward across all CIOs. Ms. Ryder thought that made sense. Dr. Robinson also liked the idea of more fact-finding by speaking with someone from TFAH and to Ms. Berger. Then the HDS can further discuss the findings from those contacts.

Dr. Richardson thanked Ms. Ryder and Dr. Pestronk for their work on this activity, acknowledging the amount of time and effort they spent on talking to people to better understand the PPHF.

### **Updates on HDS Priorities**

Dr. Liburd announced that at the end of 2013, OMHHE was expanded to include OWH and the Diversity and Inclusion Management Program. OMHHE has been working closely with these groups for about a year, and has completed a strategic planning process. Now there is a sense moving forward of how to create synergy between the three units in order to contribute to more robust and more meaningful outcomes. Dr. Liburd said she was very pleased to have in attendance Ms. Diane Dennis-Stephens, a Health Scientist in the OWH, to speak about OWH; and Dr. James Nelson, CDC's Chief Diversity Officer, to speak about the Diversity and Inclusion Management Program.



## **Office of Women's Health Overview**

Ms. Dennis-Stephens indicated that the OWH was established in 1994 and authorized by the Patient Protection and Affordable Care Act (PPACA) in 2010. The OWH mission is to support and protect the health and safety of women and girls by addressing health issues and identifying solutions. The goal of OWH is as follows: Through leadership, targeted collaboration, and communication, OMHHE will advance CDC's research, policy, and prevention initiatives for public health action to promote and improve women's health. While OWH's mission and goals are similar to those before joining OMHHE, they have been modified to some extent to ensure that they encompass everything the OMHHE plans to incorporate in its goals and mission.

OWH's major activities include health promotion through its webpage, social media, and its eNewsletter; as well as partnerships/collaborations with CDC centers, other federal agencies, and national health organizations. In terms of health promotion, a large part of OWH's activities are communications-based. OWH translates CDC program science into a language that the public can better understand, and bundles information to take a more holistic approach to healthy living. For example, about five years ago a health message titled the "The 12 Ways to Health," was developed and put to the tune of "The 12 Days of Christmas." The link to "The 12 Ways to Health" is <http://www.cdc.gov/family/holiday/12waysSong.htm> and here are the 12 ways to health:

1. The first way to health, said the CDC to me  
Wash hands to be safe and healthy.
2. The second way to health, said the CDC to me  
Bundle up for warmth, and wash hands to be safe and healthy.
3. The third way to health, said the CDC to me  
Manage stress, bundle up for warmth, and wash hands to be safe and healthy.
4. The fourth way to health, said the CDC to me  
Don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.
5. The fifth way to health, said the CDC to me  
BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.
6. The sixth way to health, said the CDC to me  
Fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.
7. The seventh way to health, said the CDC to me



Get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

8. The eighth way to health, said the CDC to me

Get your vaccinations, get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

9. The ninth way to health, said the CDC to me

Monitor the children, get your vaccinations, get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

10. The tenth way to health, said the CDC to me

Practice fire safety, monitor the children, get your vaccinations, get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

11. The eleventh way to health, said the CDC to me

Prepare dinner safely, practice fire safety, monitor the children, get your vaccinations, get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

12. The twelfth way to health, said the CDC to me

Eat well and get moving, prepare dinner safely, practice fire safety, monitor the children, get your vaccinations, get exams and screenings, fasten belts while driving, BE SMOKE-FREE, don't drink and drive, manage stress, bundle up for warmth, and wash hands to be safe and healthy.

In addition to bundling and translating information, OWH also hosts a very robust website that includes women and family health issues. Family health was included because oftentimes, women are the gatekeepers of health for the entire family. In addition, OWH has a Facebook and Twitter presence and has been involved in some Twitter chats over the last couple of years. OWH also publishes a monthly eNewsletter, Health Matters for Women™, which has over 100,000 subscribers.

In terms of partnerships/collaborations, OWH works closely with other CDC programs and offices that focus on women's and girls' health issues. In addition, OWH partners with other federal agencies such as the Department of Labor (DOL) and the Veterans Administration (VA). In terms of non-federal programs, OWH has partnered with Healthy Mothers, Healthy Babies (HMHB) Coalition. This collaboration turned into a very successful campaign known as Text4Baby™. CDC helped the HMHB Coalition refine some of the messages that they offer through this program. These are free cell phone messages that go to mothers. Mothers can enter their due data, and two to three times a week, they are sent messages to help them have a healthy pregnancy and healthy baby. Texts continue for a year after the baby is born. OWH



was very proud to be involved in this highly successful campaign. OWH also partners with other national organizations such as Million Hearts® and National Women's Health Week.

OWH focuses on several priorities. Because ACA offers access to affordable healthcare and preventable care services, the first priority is to increase the use of ACA-recommended screenings and preventive services. The second priority is to raise awareness among health professionals and consumers of six priority health issues: tobacco, reproductive health, STIs, cancer, heart disease, and prescription drug overdose. In an effort to ensure that this is being done in the most efficient way possible, Ms. Dennis-Stephens has been speaking with some of the other program offices that are involved in six priority areas to find out what populations of women are at greatest risk in order to focus messages appropriately. It is no surprise that the women most at risk are usually women of color and those on the lower end of the SES scale. The third priority is to promote Science, Technology, Engineering, and Mathematics (STEM) careers for women to improve health outcomes. OWH believes that it is important for women to become involved in the diversity of STEM careers that are part of public health for the economic reason of education and having a stable job, as well as incorporating the female perspective into this work. For example, it took 25 years to figure out that women do not express heart disease in the same way that men do. If more women bring the female perspective to the field, it will contribute to expanding and improving the health of women moving forward.

For more information about OWH, Dr. Dennis-Stephens invited everyone to visit their website at [www.cdc.gov/women](http://www.cdc.gov/women).

### **Discussion Points**

Ms. Wilson asked whether the work of the OWH includes non-heterosexual women. For example, do the messages on the OWH website speak to lesbian, bisexual, and transgender women and include training for those populations.

Ms. Dennis-Stephens replied that OWH does some messages for lesbian, bisexual, and transgender women, but probably does not address them in as much depth as they should. NCHHSTP does a better job currently of reaching these populations. They typically address lesbian, bisexual, and transgender women in terms of sexually transmitted diseases (STDs).

Ms. Wilson pointed out that STDs are not the only health problem of lesbian, bisexual, and transgender women.

Ms. Dennis-Stephens agreed and emphasized that she was just pointing out that NCHHSTP does a better job, and that OWH needs to do so as well.

Dr. Liburd invited input from the HDS members about what OMHHE can do to create more synergy between OMHHE, OWH, and the Diversity and Inclusion Management Program.

Dr. Richardson noted that there are numerous similarities between the work of the OWH and the types of issues on which the HDS is focused. Much of the focus appears to regard data and the ability to use data to track progress, particularly on two of OWH's three priorities. In



assessing the equity metrics that are being developed agency-wide, it is important to include gender as one of the categories as well as the particular outcomes of interest in the effort to identify data sources.

Dr. Ro thinks a lot is missed if data are not assessed through the lens of gender, and a case could be made for men and women in terms of the various indicators. In terms of violence, her local data show that domestic violence is a major factor for women. So, efforts such as that are important. In terms of where the synergies are, what strikes Dr. Ro is that there is a translation component of the work that is very much about reaching out to communities. One area regards language access. OMHHE, OWH, and the Diversity and Inclusion Management Program should adopt policy and create Language Access Plans for these offices that is concrete in terms of translating materials into whatever the target language is. It is also important to work with partners across the nation who address smaller populations to translate materials for them as well. For people living with disabilities (PLWD), there are layers of vulnerability in terms of who becomes most vulnerable. For example, women of color with disabilities are much more vulnerable. In those areas of intersection, OMHHE, OWH, and the Diversity and Inclusion Management Program should draw out populations that otherwise do not have a voice.

In speaking with the various programs across CDC, Ms. Dennis-Stephens has received feedback that even if there are data, sometimes it is not assembled in a way that easily depicts what is occurring. For example, there may be some data on women with disabilities and there may be some data on minority women. However, there are not necessarily good data combining the two.

Dr. Ro pointed out that this is also an area of intersection with the HHS Office of Minority Health. She also noted that sometimes when people say “data” they mean that they do not have quantitative data. Not necessarily that there are rigorous qualitative data either, but the value that these offices bring is the ability to highlight and tell stories from communities. Simply sharing those stories and giving the issues a face and voice is very powerful, especially at the local level where there are little to no data. There are non-academically published data that are relevant for communities because they tell communities’ stories. CDC, like all of the other HHS agencies, has a Language Access Plan. The policy for Language Access Plans sets minimum standards; however, OMHHE, OWH, and the Diversity and Inclusion Management Program can set higher standards in showing what really can be done. In addition, more deliberate consideration should be given to communications and translation in terms of networking capabilities and building this into work plans. For example, presentations at conferences should more deliberately illustrate how these offices are acting as advocates and connectors.

Dr. Botchwey encouraged OMHHE to think through communications on the health equity side that may take advantage of the women’s health communication vehicles and sources to better promote the efforts of health equity messages. She was thinking about the many groups that women as a subset of the population spend a lot of time involved in such as schools and Parent/Teacher Associations (PTAs).

Ms. Wilson asked whether one of OWH’s health promotion messages would be getting the word out to women about enrolling or re-enrolling in the Health Marketplace.



Ms. Dennis-Stephens replied that the OWH has been ramping up for the last couple of months to promote open enrollment. She is the lead for the OWH's Coverage to Care project, for which OWH has been ramping up. A very important goal for OWH is to be much more deliberate in message development and refinement for particular audiences versus taking a scattershot approach.

Ms. Wilson stressed the importance of getting Project Officers and CIOs to recognize the importance of the Language Access Plan in the interpretation and translation of documents. From the federal perspective, there is the Plain Writing Act of 2010 that mandates all federal documents to be written in a plain language manner such that the average consumer can understand these items.

Dr. Liburd replied that that is part of OMHHE's collaboration with the Office of Communication.

Regarding synergy, Dr. Ross was curious about whether there has been a public health workforce assessment of the number of women who occupy high-level positions in public health departments and government or academic agencies.

Ms. Dennis-Stephens replied that she is currently working on such a project. She has requested data from a couple of places. She began by assessing where CDC women are in the scheme of things, and she would like to expand that to determine where students who come through CDC end up. She just recently started this project, but will update the HDS as soon as more information is available.

Dr. Horner-Johnson noted that the Disability and Health Team has had a focus on health of women with disabilities based on data-driven reasons, such as disparities in breast and cervical cancer screenings for women with disabilities and disparities in interpersonal violence for people with disabilities in general. However, issues of diversity and intersectionality are not part of the focus at this point. That still needs to be developed.

### **Diversity and Inclusion Management Overview**

Dr. Nelson reported that CDC's Office of Diversity Management was established in 2005 and concurrently published the first CDC Diversity and Inclusion Strategic Plan. The following nine goals reflect the current Diversity and Inclusion Strategic Plan for 2011-2015:

1. Leadership Commitment
2. Diversity Training
3. Recruitment
4. Retention
5. Succession Planning
6. Community Outreach
7. Employee Involvement
8. Special Emphasis Program
9. Organizational Assessments



In 2011, President Obama issued Executive Order 13583 to establish a coordinated government-wide initiative to promote diversity and inclusion in the federal workforce. Within 90 days of the date of this order, all federal agencies were directed to prepare agency-specific Diversity and Inclusion Strategic Plans. There are 34 pages of guidance for the development of these plans, broken down into three categories: Workforce Diversity, Workforce Inclusion, and Sustainability.

The Office of Diversity Management is involved in a number of efforts. CDC's first ever Diversity Culture Audit was conducted in 2012, and there are plans to repeat this audit in 2015. The Diversity Culture Audit includes an on-line survey of staff, focus groups with staff, and interviews with executives. For the inaugural survey, there was 33% participation. They are not aware of any other federal agency that has conducted a Diversity Cultural Audit. The National Aeronautics and Space Administration (NASA) conducted a cultural audit last year, but they are the only federal agency that has had a positive uptick in the Best Places to Work over the past few years.

Development is underway of the 2014 – 2019 Workforce Diversity and Inclusion Strategic Plan, which will soon be vetted. The Office of Diversity Management has been working very closely with Dr. Liburd and other CDC leadership to ensure that the plan represents CDC leadership. This is an exciting time, because in addition to the plan, the Office of Diversity Management revised its Diversity and Inclusion Executive Committee (DIESC). Plans are to increase the size of the DIESC membership to include affinity groups and organizations, and individuals in leadership and non-leadership positions throughout the organization. The first DIESC meeting was to be convened within a few days of this HDS meeting. The Office of Diversity Management increased the number of CIO-level Diversity and Inclusion Councils within its department from 3 in 2010 to 22 in 2013. That is the office's inclusion component. It is a small group of 10 to 12 individuals who discuss the climates within their units, and work on actions and activities to improve their climates. Every representative from those councils sits on the Office of Diversity Management's Committee on Diversity (COD), which meets once a month.

The Office of Diversity Management has two priorities. The first is to increase the cumulative number of diversity-competent staff and mentors at CDC from 20 to 160 by 2017, and the second is to increase the number of employees who complete the CDC Exit Survey from 3.68% in 2013 / 2014 to 54% in 2018. When he introduced the first priority, it was very aggressive. The intent was to have a two-day development program, with the first day focused on diversity and inclusion competency and the second day focused on performance management in a non-discriminatory, equity-based manner. The most unique thing about the two-day session was that it was preceded by an online product designed by the office. There was also a post-program online product that all participants take. The in-person instructors and the office's staff who work with the instructional designer worked together to ensure that the online product dovetails with real-world CDC challenges. Three components were used (e.g.,) EVS for the survey, The Best Places to Work in the Federal Government®, the Performance Management Appraisals Program (PMAP) study, and the Cultural Audit to determine 20 areas to work on. Those were narrowed down to the five top areas that were incorporated into the competency development piece. In terms of the second priority to use the HHS/CDC Exit Survey, the goal to raise the rate to 14% for 2014 was not as high as the office would like. However, the Office of



Diversity Management is now in discussion with their partners, Human Resources Office (HRO), and the policy developers at CDC to determine ways to institute a mandatory Exit Survey.

### **Discussion Points**

Ms. Wilson asked for information about the major findings from the 2012 Diversity Culture Audit. She also noted that the previous day, CAPT Wilkins began the conversation about diversity-competent staff/mentors. She asked for an explanation of the purpose of diversity-competent staff/mentors, and in the training they are receiving, what five top areas are being addressed.

Regarding the audit, Dr. Nelson indicated that a professionally developed product was utilized. Out of that came a list of “red flags.” Each of the 22 Diversity and Inclusion Councils received an independent study. The number one area that was identified as a “red flag” for the agency as a whole regarded talent and recruitment. The various departments had a different array of “red flags.” The focused groups expressed concern about what efforts would be made toward improvement following collection of data and sharing of the findings. They pointed out that these types of activities had been done previously, but nothing changed. They also wanted improvements made with regard to the PMAP. In terms of the diversity-competent staff/mentors training, some of the themes were pervasive and sometimes unchecked bullying, equity in PMAPs dealing with race, and internal-climate areas. A PMAP study six to seven years ago found that the largest gap is between African Americans and other races at CDC as they receive their performance management evaluations.

Ms. Wilson asked what type of employee resource groups are available at CDC. Noting that a lot of the work being done is data-driven, she suggested including a question in the 2015 Diversity Culture Audit regarding whether responders belong to any employee organizations. Based on data from other companies, oftentimes people belong to an employee resource group, infinity organization, et cetera. It would also be beneficial to include a question regarding any improvements that have been observed in terms of the concerns raised in the previous audit.

Dr. Nelson replied that the Management Analysis and Services Office (MASO) at CDC has a policy that established any type of employee organization that might exist. There are employee organizations for African Americans; Native Americans; Asian Americans; Hispanics; Lesbian, Gay, Bisexual, and Transgender (GLBT); Veterans; and Christian Fellowship. These groups existed, but never before had they come together. There was no trust in the agency or the data. One of the first things he did in 2007 was establish a quarterly meeting of every representative for every organization. The Office of Diversity Management convenes them, shares with them the status of the diversity initiative, and lets them talk to one another and the office about their needs.

Dr. Botchwey expressed an interest in knowing more about how people of color and women are doing in terms of moving into managerial and leadership positions within CDC, as well as what action strategies are being taken to help move African Americans, Latinos, and women into higher level positions at CDC.



Dr. Nelson replied that his hope is that because the Diversity Executive Committee involves people from leadership groups and there is a staffing component, they will be able to track this. However, that is one of the challenges. They also collaborate with CDC's Equal Opportunity Employment (EEO) group, which deals in many ways with the barriers associated with minorities as they move into different positions. Most of the action strategies being taken are done through partnerships. Data is a very important component. There is a food company that is ranked #1 on diversityinc.com. Their data dashboard pertaining to demographics and leadership positions is linked to bonuses. However, that cannot be done in the federal government. CDC's HR department is working on data dash-boarding that offer more visibility into the different demographics that exist within the units. The Office of Diversity Management also has a six-month score card as part of the strategic plan, which uses SharePoint, and all of the CIOs must report their status on the cultural audit component and the recruitment, retention, and promotions component.

Mr. Vargas said he was encouraged to hear that sexual orientation is being addressed, and expressed his hope that disability and gender identity are being assessed as well. Data on the racial/ethnic minorities specific to the CDC workforce might inform and lead to strategies for promotion of people of color and women into key management positions.

Dr. Nelson indicated that those data are part of the EEO MD7 Management Directive 715 that are collected every year. In the civilian sector, this is known as "affirmative action planning." All of the demographics are assessed and the barriers are determined. The Office of Diversity Management provides input into that product. The revised Diversity Executive Committee will have four action teams, each focused on a specific topic: Succession Planning, Performance Management, Recruitment, and Retention.

Ms. Wilson asked whether there is any compensation for executives tied to how they perform based upon any performance management measures, which is occurring in the corporate sector.

Dr. Nelson responded that the Factor Evaluation System (FES) has a component of performance measurement critical elements that addresses support for diversity and inclusion. CDC has its own element for all supervisors supporting diversity and inclusion and targeted recruitment. They are now trying to assess whether people are actually supporting these efforts. It is not linked to compensation.

Dr. Horner-Johnson said she thought it was very important for the support of diversity and inclusion to be an expectation. If people are paid for it, it takes away the incentive to do it because it is the right thing to do.

Dr. Richardson emphasized that in order to make change and create progress, measurement is necessary. There are strategies to hold supervisors and managers at every level of the organization accountable, independent of whether that is tied to bonuses. It is about making this an expectation so that their success in this area becomes part of their performance appraisal. There are many models for this in the corporate, academic, and government sectors. There is also a significant amount of information about what works and how to make progress.



She expressed her hope that the Office of Diversity Management is taking advantage of that information and experience in terms of CDC, because it seems that there is quite a lot of work to be done.

Ms. Ryder asked whether anyone was familiar with the Hispanic Agenda for Action (HAA) from the 1990s. This was the result of a very enthusiastic group meeting in Los Angeles, which survived for many years. The group focused across HHS on a Hispanic Agenda for Action to increase recruitment of Hispanics within HHS as a government employer. In the early 2000s, that was rolled into Executive Orders. She encouraged Dr. Nelson to review those, because they included very strong recommendations that have not been acted upon, and many of the points are valid and are still true today. Ms. Ryder received a copy of the Hispanic Agenda for Action from one of the people who participated, who currently works in the HHS Office of Minority Health, which she offered to share.

Dr. Nelson said that about six years ago, the EEOC convened a workgroup for Hispanics that made recommendations for activities for the federal government. One of the activities was to make the language requirements on announcements mandatory. He was not sure whether that was the same initiative. He shared his email address with Ms. Ryder so that she could email him the Hispanic Agenda for Action that she has.

Dr. Ro thought that for the first White House Initiative on Asian Americans/Pacific Islanders, inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the federal workforce was a major priority.

Given that the OWH is now under OMHHE's purview, Dr. Botchwey wondered whether the HDS would provide guidance or oversight regarding women's health and if they should make sure that the subcommittee includes a women's health perspective.

Dr. Dennis-Stephens replied that the OWH does not have its own advisory board, but she thought it would be a great idea.

Dr. Liburd indicated that they could make this an addition to the HDS.

### **Emerging Issues / Meeting Dates for the Coming Year**

Dr. Richardson led a discussion during this session that focused on emerging issues, future agenda items, 2015 meeting dates, and reflections on the State of Health Equity Forum. She and Dr. Liburd have been discussing the continuation of the series of presentations from center directors. The next HDS meeting will be February 26, 2015 at 11:00 AM EST via teleconference. They thought that it would be beneficial to include a presentation from NCHHSTP on the next HDS agenda, because that center deals with many very important disparity population issues. Inclusion of a presentation from NCHS on data collection also would be beneficial, particularly with respect to the LGBT data collection plan. Efforts are underway to reach out to other FACA-chartered committees and the HHS.

Potential topics suggested for the future included the following:



- ❑ The *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* (2011) was at one point framed as a broader health disparities report and included some data on LGBT populations, disability, SES, et cetera. At some point, that all disappeared and it became a racial and ethnic health disparities report. There was a plan to address disability in a separate document, but that also fell by the wayside for political reasons. It would be beneficial to understand the following:
  - Why was that change made?
  - What are the plans for the future in terms of whether the report will be updated?
  - Is there a potential for the plan to be broadened again?
  - What role CDC might play?
  
- ❑ It would be helpful to have some discussion about data collection in terms of how to handle the multi-racial population, because that is also getting lost in the discussion.

### **Discussion Points**

Dr. Ro expressed gratitude to Dr. Liburd and her staff for convening the State of Health Equity Forum. Establishing this as a continual annual event sets a good path for ensuring that this issue is visible within CDC. The issue of capacity-building was a clear theme, and she emphasized that this continues to be an important issue for communities. NCHHSTP has a great model of how this has been done and resourced, and should be replicated throughout the rest of CDC. She said she always enjoys hearing Dr. Williams speak, and that having HDS members offers a voice that it is hard to express from the inside. She suggested making that a consistent part of the program, perhaps closer to the beginning before people leave. Hopefully people get not only sharing, but also inspiration and energy. Dr. Ro also expressed her hope that the folks at CDC, especially those who are championing and doing the work, also are aware about what other efforts are occurring across the nation. Whether it is through racial healing work, racial equity work, equity and social justice work, that can help to inspire and create opportunities and thinking through strategies. The HDS should be used as an opportunity to help inform OMHHE in order to help make those linkages.

Dr. Liburd expressed her hope for that to be bidirectional—that the HDS members will take the messages back to their networks about the work going on within OMHHE.

Dr. Richardson said she was most struck by the presentation on child maltreatment. Constructing that kind of conceptual model and then using it to inform actions and interventions is a useful way to broaden the way people are thinking about what they do. It is one thing to see the generic logic model, but quite another to see it used in that way. That should also be a model for programs as they try to understand the outcome(s) that needs to be impacted, all of the factors that go into that, and how they play out. That completely changes the thinking about what to do to address a problem once a problem is conceptualized and visualized in that way. She thought that was very powerful.



Hector Vargas added his appreciation to the staff for assembling a great forum. He said he was looking to the next couple as well. He was struck that there is no lack of successful models and frameworks within which to do this work, which was evident during the forum. The challenge regards how to disseminate those models more widely in order to apply the health equity lens in everything the agency does.

Dr. Horner-Johnson was curious about how open the State of Health Equity Forum is to people inside and outside of CDC, and what the plans are for making the information public. A huge number of people could benefit from this information.

Dr. Liburd replied that the primary method for disseminating the information is through the special issue of the *Journal of Public Health Management and Practice*. OMHHE is developing a strategy for how to distribute that internally and externally. The forums began as an internal gathering, but then people hear about it and want to attend. Of course, they are welcomed, but it was never intended to be a public event. Every year she sees people attend who want to keep up with the process, so they get a chance to see how CDC works through a consensus-building process around this type of activity. It is rigorous, evidence-based, and is a good place to start. It is a beginning and deliberate effort to push this forward. OMHHE must be prepared to answer their colleagues' questions internally, or the conversation will be very short.

Dr. Botchwey stressed the importance of who from CDC were not present at State of Health Equity Forum. Last year, there were four times the number of people in attendance. That may have to do with the location on the Chamblee Campus versus the Roybal Campus. Looking forward, it is important to ensure that there is greater attendance from internal CDC members, as well as maintaining the outside interest that has been growing.

Dr. Liburd replied that the room in which the HDS was meeting was larger than the room at the Chamblee Campus. Parking is always an issue at the Roybal Campus, which is one problem. People also were able to access the forum via teleconference, so they can try to find out how many people called in. Envision was also available, so there could have been participants in rooms through the various CDC campuses. She did not know whether CDC-TV was also available, which permits people to sit at their desk and participate. She also noticed that people were coming in on a certain side, so that one side filled up. It was a major commitment of time in an average day at CDC as well. Hopefully, the forum will stimulate some additional collaboration among scientists and practitioners at a broader rather than categorical level.

Ms. Wilson noted that she often attends conferences about health equity, health disparities, diversity, inclusion, et cetera and is struck by the "preaching to the choir." For example, there were not necessarily representatives from the communities that are disproportionately affected by health inequities in the room (e.g., Asian and Pacific Islanders, Native Americans, Alaska Natives, Latinos). It cannot be only black and brown people in the room. Other allies should be present as well, and the audience did not look as diverse as it should have been. White allies must be in the room as well. This affects our entire society. It cannot be the problem of those disproportionately affected. Everyone is needed. It is imperative to reach and engage a broader audience for whom this may not be everyday work, but should be a cross-cutting



element in their work. A business case can be made for how being a diverse, inclusive environment can actually impact a company, government, or society better.

Dr. Liburd indicated that when they have more time, she will share with HDS how things are done in the agency and who picks up and sustains the focus and concern with this type of work, and how meaningful it is for them to enter a room to see many others who are engaged in similar types of work. Last year, a center director attended who stayed the entire time. She agreed with the importance of considering how to push this out to people who are not in the room. A different approach may be needed with those who want to be their allies who are not engaged in this work on a daily basis. A major priority for Dr. Liburd is to be able to articulate in a few words why health equity is good for everybody. A health communications person can help to frame that. Americans tend to be inwardly focused, “Everything is okay at my house, so everything is okay.” It is important to demonstrate in a compelling way that things can be better.

Dr. Dennis-Stephens agreed that here in America, issues do not become relative to people unless it is affecting them personally. The Ebola outbreak is a great example of this. Ebola has been around for a long time. As long as it was isolated in one place, it was fine. When it crossed the water, it became a problem. It is important to explain how health equity is relative to everybody now, not later when it affects them. Usually, by the time something affects someone, it is out of hand.

In some of the health work Dr. Botchwey has done in Atlanta, she found a similar issue. When an individual is familiar with *his* health status and *his* quality of life, translating that to the county level of health and quality of life is not possible because it is too big of a jump. When he is shown the data about his own neighborhood where he spends 60% of his time and his perception of his quality of life does not align with the data about his neighborhood, then he is concerned. He questions the data and wonders how he can improve the situation. Making that “place matters” translation for people on a smaller place-based scale is very important in terms of making a connection between an individual’s health/experience and the health/experience of the people around that individual, and how there is a synergistic relationship between one and the other. In response to a question from Dr. Liburd about how to translate that when it is across town, Dr. Botchwey used Atlanta as an example. If someone lives on the North side and she lives on the West side but works in the restaurant, shops, and other places that the person living on the North side perceives as critical amenities and she cannot get to work because it takes an hour and a half to get there or her child is sick, so she cannot be there to support the person from the North side’s quality of life. Linking one environment to another to illustrate the co-dependencies and synergies is really important. However, this is difficult to do without smaller scale level data.

## **Day 2: Public Comment Period**

No public comments were offered during this session.



### Wrap-Up / Adjournment

Dr. Richardson thanked everyone for the very important conversations and suggestions throughout this meeting. The next teleconference meeting is tentatively scheduled for February 26, 2015 at 11:00 am EST. It was suggested that the next in-person meeting be convened on April 17, 2015 to align with the CDC event that coincides with the commemoration of the 100<sup>th</sup> anniversary of Booker T. Washington's death. If this is not possible to arrange, the second choice would be for the spring meeting to coincide with the ACD meeting on April 23, 2015.

*With no further business posed or questions raised, Dr. Richardson wished everyone safe travels and officially adjourned the November 12-13, 2014 HDS meeting at 2:38 PM EST.*



## Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 12-13, 2014 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:

Botchwey, Nisha D., PhD, MCRP, MPH  
Associate Professor, School of City and Regional Planning  
Georgia Institute of Technology College of Architecture

Duran, Bonnie M., MPH, DrPH  
Associate Professor, Health Services  
School of Public Health and Indigenous Wellness Research Institute  
University of Washington

Horner-Johnson, Willie, PhD  
Research Assistant Professor  
Oregon Health & Science University  
Institute on Development and Disability

Mullen, Jewel M, MD, MPH, MPA  
Commissioner  
Connecticut Department of Public Health

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

Ro, Marguerite, DrPH  
Chief Assessment, Policy Development, and Evaluation Section  
Public Health Seattle – King County

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.

Vargas, Hector, JD  
Executive Director  
Gay, Lesbian Medical Association (GLMA): Health Professionals Advancing LGBT Equality



Williams, David R, PhD  
Florence & Laura Norman Professor of Public Health  
Professor of African and African American Studies and of Sociology  
Director, Lung Cancer Disparities  
Co-Leader, Cancer Risk Reduction and Disparities Program  
Harvard School of Public Health  
Department of Society, Human Development, and Health

Wilson, Cheri, MA, MHS, CPHQ  
Faculty Research Associate  
Health Policy and Management Department  
Hopkins Center for Health Disparities Solutions  
John Hopkins Bloomberg School of Public Health

**CDC Staff Present:**

Baker, Gwen  
Program Specialist / Assistant to the Director  
Office of Minority Health and Health Equity

Dicent- Taillepierre, Julio, MS  
Public Health Analyst/Team Lead  
Office of Minority Health and Health Equity

Dennis-Stephens, Diane  
Health Disparities Officer  
Office of Minority Health and Health Equity

Liburd, Leandris, MPH, PhD  
Director  
Office of Minority Health and Health Equity

Lipshutz, Judith (Judy), MPH  
Public Health Analyst  
Office of the Director  
Office for State, Tribal, Local and Territorial Support

Nelson, James, PhD  
Chief, Diversity and Inclusion Program  
Office of Minority Health and Health Equity

Penman-Aguliar, Ana, PhD  
Associate Director for Science  
Office of Minority Health and Health Equity



Roberts, George, PhD  
Senior Advisor to the Director  
Office of Minority Health and Health Equity

CAPT Craig Wilkins, MPH  
Acting Associate Director for Tribal Support  
Office of Minority Health and Health Equity

Williams, Kem  
Acting Deputy Director  
Office of Minority Health and Health Equity

**General Public Present:**

Chambers, Shonta  
Patient Advocate Foundation

Cox, Kendra  
Medical & Scientific Writer/Editor  
Cambridge Communications & Training Institute

Laura Harker  
Health Equity Intern  
Office of Minority Health and Health Equity

Wallace, Stephanie-Henry  
Medical & Scientific Writer/Editor  
Cambridge Communications & Training Institute



## Attachment #2: Acronyms Used in this Document

Acronym	Expansion
AAMC	Association of American Medical Colleges
ACA	(Patient Protection and) Affordable Care Act
ACD	Advisory Committee to the Director
ACS	American Community Survey
ACEP	American College of Emergency Physicians
AHRQ	Agency for Healthcare Research and Quality
AL	Allostatic Load
APA	American Planning Association
APHA	American Public Health Association
APIAHF	Asian & Pacific Islander American Health Forum
ASH	Assistant Secretary for Health
ASTHO	Association of State and Territorial Health Officials
BEPHC	Built Environment and Public Health Clearinghouse
BLS	Bureau of Labor Statistics
BRFSS	Behavioral Risk Factor Surveillance System
CBC	Congressional Black Caucus
CDC	Centers for Disease Control and Prevention
CEHCD	Commission to End Health Care Disparities
CHDIR	<i>CDC Health Disparities and Inequalities Report</i>
CHSI	Community Health Status Indicators
CIO	Centers, Institutes, and Offices
CLAS Standards	Culturally and Linguistically Appropriate Services in Health and Health Care
CMS	Center for Medicare and Medicaid
COD	Committee on Diversity
CUPS	Public Health Scholars Program
DFO	Designated Federal Official
DHAP	Division of HIV/AIDS Prevention
DIESC	Diversity and Inclusion Executive Committee
DIS	Disparity Impact Statement
DOL	Department of Labor
DPH	Division of Population Health
DSTD	Division of STD Prevention
ED	Executive Director
EEO	Equal Opportunity Employment
EHR	Electronic Health Record
EMR	Electronic Medical Record
FDA	Food and Drug Administration
FES	Factor Evaluation System
FIHET	Federal Interagency Health Equity Team
FOA	Funding Opportunity Announcement
FOIA	Freedom of Information Act
FY	Fiscal Year
HAA	Hispanic Agenda for Action
HAIs	Healthcare-Associated Infections
HBCU	Historically Black Colleges and Universities
HDS	Health Disparities Subcommittee
HEI	Health Equity Indicator
HHS	(United States Department of) Health and Human Services
HIMS	Health Information Management and Systems
HMHB	Healthy Mothers, Healthy Babies Coalition
HRSA	Health Resources Services Administration



Acronym	Expansion
IOM	Institute of Medicine
JPHMP	Journal of Public Health Management and Practice
LEP	Limited English Proficiency
MASO	Management Analysis and Services Office
MMWR	<i>Morbidity and Mortality Weekly Report</i>
NASA	National Aeronautics and Space Administration
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NACCHO	National Association of County and City Health Officials
NCFH	National Center for Farmworker Health
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NCVHS	National Committee on Vital and Health Statistics
NGOs	Non-Governmental Organizations
NHANES	National Health and Nutrition Examination Survey
NHDR	National Healthcare Disparities Report (AHRQ)
NHQR	National Healthcare Quality Report (AHRQ)
NIH	National Institutes of Health
NHIS	National Health Interview Survey
NIMHD	National Institute on Minority Health and Health Disparities
OADP	Office of the Associate Director for Policy
OBHE	Office of Behavioral Health Equity (SAMSHA)
OMHHE	Office of Minority Health and Health Equity
OSTLTS	Office for State, Tribal, Local and Territorial Support
OWH	Office of Women's Health
PHAP	Public Health Associates Program
PHHS	Preventive Health and Health Services
PHR	Patient Health Record
PLWD	People Living With Disabilities
PMAP	Performance Management Appraisals Program
PPHF	Prevention and Public Health Fund
PTA	Parent/Teacher Association
REACH	Racial and Ethnic Approaches to Community Health
RFA	Request for Funding Announcement
RHIO	Regional Health Information Organization
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Socioeconomic Status
SDH	Social Determinants of Health
SME	Subject Matter Expert
SNMA	Student National Medical Association
STD	Sexually Transmitted Disease
STEM	Science, Technology, Engineering, and Mathematics
STLT	State, Tribal, Local, and Territorial Subcommittee
TFAH	Trust for America's Health
US	United States
VA	Veterans Administration

