



## Minutes from the April 25, 2013

## CDC Advisory Committee to the Director

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Advisory Committee to the Director: Record of the April 25, 2013 Meeting

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## **Advisory Committee to the Director Record of the April 25, 2013 Meeting**

The Centers for Disease Control and Prevention (CDC) convened a meeting of its Advisory Committee to the Director (ACD) on April 25, 2013, at the Arlen Specter Headquarters and Emergency Operations Center in Atlanta, Georgia. The agenda included a review of current issues regarding Surveillance, Epidemiology, and Laboratory Services (SELS) and public health/health care collaboration; updates from the State, Tribal, Local and Territorial (STLT) Workgroup, Ethics Subcommittee, Health Disparities Subcommittee (HDS), and Global Workgroup (GWG); and a discussion of ACD future directions and workgroup/subcommittee structure.

### **Welcome and Introductions**

Dr. Greenberg (ACD Chair) called the meeting of the Advisory Committee to the Director, Centers for Disease Control and Prevention, to order at 8:38 am. He asked that those present and on the telephone introduce themselves. A quorum of ACD members was present, and ACD members were asked to disclose any conflicts of interest. The following ACD members disclosed conflicts of interest:

- Dr. Herminia Palacio's agency receives indirect funding through CDC through the state of Texas.
- Dr. Lynn Goldman's university receives CDC funding.
- Dr. David Fleming's department receives CDC funding.
- Dr. Tom Farley's department receives grant support from CDC.
- Dr. Nisha Botchwey's university receives CDC funding.
- Dr. Georges Benjamin's association receives CDC funding.
- Dr. Dileep Bal's district receives CDC funding through the state of Hawaii.
- Dr. Alan Greenberg's department receives indirect CDC funding.

### **Director's Update and Discussion**

Dr. Thomas R. Frieden (Director, CDC) encouraged ACD members to be blunt in their advice and to offer suggestions for how their time together could be better spent. He thanked the ACD members who were extending their tenure on the committee and expressed appreciation to Dr. Kelly Henning, who was rotating off of the committee. He indicated that CDC has made a number of advances in a variety of areas in the past year, and Americans are better protected from a variety of problems.

CDC was involved in the fungal meningitis outbreak in many ways. Tennessee's state epidemiologist is a graduate of the Epidemic Intelligence Service (EIS). Her staff was funded by the healthcare-associated infections (HAI) program. Within days of the beginning of the outbreak, CDC worked with health departments in 23 states to notify 14,000 patients that they had been exposed to fungal meningitis. The contaminated objects were identified rapidly and were removed from shelves before a recall was issued. CDC consulted with national fungal meningitis experts on frequent conference calls to generate clinical guidance for diagnosis and treatment. CDC laboratories developed a real-time polymerase chain reaction (PCR) test for the unusual mold involved in the outbreak. The state health laboratory of Virginia, which made the first



diagnosis, had previously attended a CDC training session about how to identify fungal meningitis.

Progress has been made in global polio and HIV. CDC provides approximately half of the HIV treatment through the President's Emergency Plan for AIDS Relief (PEPFAR) program, and they are doing so at decreasing cost with increasing sustainability. Most of the CDC portfolio goes to local partners, including health departments and non-governmental organizations (NGOs). Through PEPFAR, 5.3 million people around the world are undergoing treatment for HIV. More than 250,000 children did not get HIV last year, thanks to PEPFAR. The PEPFAR infrastructure is providing opportunities for laboratory systems in Africa to grow stronger, and for epidemiologic training to improve. The African Society for Laboratory Medicine (ASLM) was created last year. PEPFAR has supported nine Field Epidemiology Training Programs (FETPs) across Africa. FETP is similar to EIS, and in a few years, there will be more FETP graduates than EIS graduates. Of the FETP graduates, 80% remain in their home countries, usually in positions of leadership in public health.

CDC is monitoring its morale, listening and responding to employee concerns. The Employee Viewpoint Survey (EVS) is a government-wide survey that allows for comparisons across government agencies. Among analogous groups, CDC rose from the bottom 15% in overall ranking to the top 12% in five years. This improvement comes despite a pay freeze and a freeze on bonuses. The next EVS will be administered in May 2013.

The budget is the largest single administrative challenge that CDC faces. The largest portion of CDC's budget of approximately \$6 billion is allocated to infectious disease, which is funded at \$2.4 billion. The next-largest funding categories are chronic disease, birth defects, injury prevention, public health leadership and infrastructure, global disease, environmental- and work-related issues, monitoring health and ensuring laboratory excellence, and protection from natural and bioterrorist threats.

The fiscal year (FY) 2014 budget authority for CDC is \$1.2 billion below the FY 2010 budget authority. A continuing resolution (CR) keeps the FY 2013 funding at the 2012 level, but a 5% reduction will still affect the CDC budget, in addition to a \$263 million reduction to the Prevention Fund. The evaluation transfer dollars that have been authorized by Congress in the past will not be authorized for 2014. These cuts affect CDC's ability to protect the US and to support state and local health departments, which are already stressed by budget cuts. State and local health departments have lost 45,000 jobs in recent years. CDC has increased the proportion of its budget going to state and local health departments from 59% to 64%, growing the funds that go to the field despite declining overall budgets. CDC has cut administrative costs as much as possible. At this point, the additional budget cuts will affect programs, resulting in fewer vaccinations, slower responses to outbreaks, and more cases of preventable diseases such as cancer and heart disease.



CDC will pursue three core directions in the coming years:

- Improve health security at home and abroad
- Better prevent the leading causes of injury, illness, disability, and death
- Strengthen the collaboration between public health and healthcare

CDC's most important budget initiative in 2014 is the Advanced Molecular Detection initiative. New and exciting techniques are being developed to sequence molecular genomes in hours, where the process used to take weeks or months. With advanced supercomputing, there are now remarkable ways to look at patterns of resistance, evolution and progression toward more virulence, and to identify missing genomes and identify modes of transmission more quickly. If CDC does not pursue these technologies, the US will fall behind in its ability to detect outbreaks, especially as culture-independent diagnostic tests, such as dipsticks, will lose their ability to detect outbreaks.

From 2011 to 2012, all countries save Nigeria that are endemic for polio observed decreases in polio rates. There are half as many polio cases in 2013 as there were at the same time in 2012. Cases have only emerged in Afghanistan, Pakistan, and Nigeria. Polio programs in many of the endemic countries have continued to improve, but severe security problems are causing challenges, especially in Pakistan and Nigeria.

Progress has been made on many of the winnable battles. The tobacco campaign "Tips From Former Smokers" is in its second year. Its first year resulted in over one million Americans trying to quit smoking, and an estimated 100,000 succeeding. Tens of thousands of people will not be killed by tobacco because of that campaign, and healthcare costs will be saved. The rates of adult tobacco use have stalled in the US, however, and it is important to see those rates decline again. Encouraging declines are occurring in healthcare-associated infections. There are concerns about emergent resistant organisms, particularly gram-negative Carbapenem-resistant Enterobacteriaceae (CRE). The US is on track to meet an ambitious target of a 20% decline in teen pregnancy. Regarding nutrition, there has been progress in breastfeeding. Some areas of the US have observed declines in childhood obesity, but those rates remain far above the baseline of a generation ago. There has been less progress in food safety than hoped, given the number of outbreaks and pathogens. Motor vehicle injuries are on track to decline by approximately one-third. In terms of HIV, the number of new infections has not been reduced as much as CDC hoped, but there is a better roadmap for accomplishing that goal, and CDC modified its program accordingly.

The focus on strengthening public health and healthcare started with the Million Hearts Campaign. Over a year after its launch, it is clear that this campaign is the right approach; however, it is extremely difficult. The approach relies on reducing the need for treatment through community prevention, including tobacco control, sodium reduction, and trans-fat elimination; and improving treatment by focusing on the "ABCs,"



aspirin, blood pressure, cholesterol, and smoking; health information technology (IT); and clinical innovations.

With this approach, the clinical system can save lives. There is a long way to go. Blood pressure control, even among insured patients, is only 50%. Canada has focused on this issue and has achieved a control rate of approximately 75% in community surveys. In the United Kingdom, with universal coverage and clinical indicators above 90% on blood pressure control, community surveys show a 36% blood pressure control rate. Access and tracking are not sufficient to address these issues. Real, community-level numbers are needed.

There are three essential components to improving clinical care:

- Focus: Simple, aligned, quality measures in a consistent, monthly feedback mechanism can lead to improvements in one year.
- Information: Clinical decisions, reminders, and registries.
- Team-Based Care: A high-performing Kaiser organization in Colorado used 17 clinical pharmacists in a call center to reach out regularly to 14,000 high-risk patients to ensure that they were on treatment. This effort resulted in 80% control. Previous efforts had reached high control levels, but were not sustainable because an ongoing system was not in place. The Ellsworth Clinic in rural Wisconsin is a three-doctor practice with one strong office manager, who calls patients to ensure that they are on treatment. These two examples illustrate the importance of all members of the healthcare team functioning at a high level; otherwise, the system will be expensive and low-performing.

There are misconceptions about what CDC does, particularly regarding clinical care. Approximately 95.5% of CDC's budget does not go toward clinical care. The \$252 million that is directed toward clinical care is chiefly directed toward the Breast and Cervical Care Program, which is a Congressionally-directed program to provide breast and cervical cancer screening to uninsured women. Even if the most optimistic scenarios of enrollment as a result of the Patient Protection and Affordable Care Act (ACA) are realized, that program will not have sufficient resources to meet need.

CDC's second-largest clinically-related budget commitment is the immunization program. It is not easy to ensure that health departments are paid by insurers for services that they provide, and many doctors are opting not to provide immunizations due to the expense and complicated nature of doing so. CDC hopes to transform the system so that the agency only pays for immunizations for persons who are truly uninsured; however, in the event of an outbreak, everyone will need to be vaccinated. CDC hopes to increase rates of HIV testing in clinical settings and to institute testing in community venues. Another clinical care budget commitment is the Infertility Prevention Program. This Congressionally-directed program supports Sexually Transmitted Disease (STD) clinics and prisons to reduce infertility and treat Chlamydia. In addition, CDC supports a small colorectal cancer program.



Much of CDC's work aims to improve clinical care through a focus on the way systems work, are tracked, and coordinate with the community. This work focuses on three areas: data, services, and drivers. CDC can provide information and data to enrich the clinical environment, and vice versa. Public health, including CDC, can support and/or coordinate core clinical services, such as STD clinics. Virtually every part of CDC works with priority clinical services. Some services, such as the Diabetes Prevention Program and telephone quitlines, reside "in between" the clinical and community environments. These individual services are provided, or overseen by, public health. Public health and CDC can drive issues such as reimbursement rates, training, and capacity.

Dr. Frieden concluded by noting that he is inspired and amazed by the quality, dedication, knowledge, and focus of CDC staff at every level.

### **ACD Agenda Overview and Workgroup Update**

Dr. Greenberg explained new changes to the ACD meeting format, noting that additional suggestions for changes were welcome. The seating arrangement was changed to bring CDC leadership and staff in closer proximity to the ACD to promote engagement and interaction between the groups. The ACD meeting focuses on the efforts of the workgroups and subcommittees and will include an opportunity for CDC leadership to identify current, pressing public health issues for input from ACD. In the future, CDC staff or ACD members can propose these high-impact issues, and CDC will decide which should be included on the agenda. Equal time will be allotted to Power Point presentations and to ACD discussion.

Ms. Carmen Villar (Chief of Staff, CDC, and Designated Federal Officer, ACD) explained that when Dr. Frieden joined CDC, the ACD formed workgroups based on the strategic priorities that he set for the agency. Those workgroups focused on surveillance, epidemiology, and laboratory issues; state, tribal, local and territorial issues; global issues; and policy. ACD also established a communications workgroup and continued the existing two subcommittees on ethics and health disparities. The difference between a subcommittee and a workgroup lies in the transient nature of a workgroup. A subcommittee is part of the foundation of ACD's work all of the time, while workgroups serve on an ad hoc basis to address issues of the day.

In the fall and winter of 2012, CDC's Office of the Director evaluated the workgroup and subcommittee structure, considering priorities and what had been helpful in the past, and consulting with the Designated Federal Officials (DFOs) of the different groups. Ms. Villar presented ACD with a chart detailing the current state of the workgroups and subcommittees, as well as background information regarding why the group was established. She shared suggestions from CDC staff regarding next steps for the workgroups and subcommittees.



- The Ethics Subcommittee has been in place for some time and has produced good work for the ACD. Because some ethics-related functions are inherent in the Office of CDC's Associate Director for Science, CDC staff recommend sunsetting this subcommittee and convening it as a workgroup on an as-needed basis.
- The Health Disparities Subcommittee (HDS) met the previous day. The group had been "on and off" in the past, but under the leadership of the current DFO and chair, they are addressing key issues. Inequities are part of most of what CDC does in public health, and CDC staff recommend continuing this subcommittee.
- The Communications Workgroup was established some years ago, but has not thrived recently. CDC staff recommend sunsetting this workgroup.
- The Global Workgroup (GWG) has provided advice to the Center for Global Health (CGH) as it has begun and developed a strategic plan. A new director is joining CGH, and CDC staff recommend continuing to evaluate the workgroup under the new center leadership, but sustaining it at least through the transition.
- The Policy Workgroup has addressed a number of key issues, and CDC staff recommend sunsetting it and perhaps reconvening workgroups on specific issues for focused discussion.
- The STLT Workgroup focuses on some of CDC's core functions and its partnerships with health departments and local jurisdictions. CDC staff perceive this work as an ongoing process and therefore recommend creating an STLT Subcommittee to institutionalize the group's work into ACD's structure.
- The SELS Workgroup disbanded recently, and there is interest in using that group on an ad hoc basis to address key issues.

### **Discussion Points**

Dr. Farley approved of the changes overall. He asked about the differences in structure of subcommittees and workgroups.

Ms. Villar answered that subcommittees are more formal than workgroups. Subcommittees fall under Federal Advisory Committee Act (FACA) guidelines.

Dr. Farley said that the STLT Workgroup has been very successful, perhaps because of their ability to meet and discuss issues more informally, such as via conference calls. He expressed concern that changing to a subcommittee structure may make it more difficult for members to communicate.

Ms. Villar answered that changing the structure should not make communication difficult. Their meetings will be public and will be announced.

Dr. Richardson supported the continuation of HDS. The group is organized and energized, and will produce valuable contributions. She invited ACD members to consider joining HDS.



Dr. Botchwey said that membership of the groups is important. If changing the STLT Workgroup to a subcommittee will require adding members to the group, then the new members should be appropriate to support the group's flow and progress.

Dr. Greenberg agreed and noted that there are only 15 members of ACD. It is important to balance the numbers of subcommittees and workgroups and to keep track of ACD members who are cycling off of the committee.

Dr. Fleming suggested that ACD see in writing the administrative differences between workgroups and subcommittees to ensure that everyone understands the changes.

Ms. Villar said that those issues would be addressed in a lunchtime presentation. There would be time on the agenda to ask more questions and to reach consensus on the staff recommendations.

Dr. Richardson observed that one of the differences between a subcommittee and a workgroup concerns CDC staffing responsibilities, such as announcing and scheduling subcommittee meetings so that they are open to the public.

### **Current Issues: SELS**

Dr. Denise Cardo (Acting CDC Deputy Director, Office of Surveillance, Epidemiology, and Laboratory Services) provided ACD with an overview of the proposed reorganization of the Office of Surveillance, Epidemiology, and Laboratory Services (OSELs). She encouraged ACD to provide feedback not just about the role of OSELs within CDC, but also its role in public health as a whole.

OSELs was created with the primary mission to provide scientific service, expertise, skills, and tools to CDC efforts to achieve its mission. When it was organized over three years ago, the office had six programmatic areas addressing all of the public health functions:

- The National Center for Health Statistics (NCHS)
- Office for Surveillance, Programs, and Practices
- Office for Public Health Informatics and Technology
- Office for Epidemiology and Analysis
- Office for Public Health Education
- Office for Laboratory Science, Policy, and Practice

The offices of surveillance and informatics were combined approximately two years ago. After the combination, OSELs consisted of NCHS, 4 offices, 10 divisions, and 24 branches. Five months ago, Dr. Cardo was tasked to assess OSELs and how it can remain relevant and add value to CDC and its partners. She and her colleagues did not aim to "fix" OSELs, but to make it more efficient, decrease duplication, and enhance customer service to CDC and its partners.



In considering the unique role of OSELS, Dr. Cardo and her team utilized the Organizational Improvement (OI) report and consulted with partners at CDC and in public health. They realized that the extant structure of OSELS created a siloed approach. There was also duplication within OSELS and with other offices and programs. The team learned that OSELS can bring innovation to CDC and to public health. The office provides value-added in this regard. As a cross-cutting organization, it was difficult to communicate OSELS's role in CDC.

Given all of these factors, Dr. Cardo and her team proposed several changes to OSELS's organization. The OSELS Office of the Director (OD) will be smaller, in an approach in keeping with other CDC offices. The OD will focus on external partners and will reinforce the value of CDC. The OD will serve as CDC's "face" for other agencies and partners and will coordinate activities between NCHS and other programs. Additionally, the OSELS OD can serve as a "gateway" to CDC as a whole, connecting partners and organizations to OSELS and CDC resources, which can be confusing to access. As OSELS includes a focus on informatics, the OD can address the many opportunities associated with Electronic Health Records (EHRs). A group within the OD will focus on "Health Information Technology (HIT) and Surveillance Strategy" and will represent CDC and public health in issues related to HIT and to coordinate activities across CDC and with partners.

We are also proposing a Center-like structure that consolidates existing Program Offices. The Center OD will be consolidated from existing Program Office ODs. This approach will allow for more cross-cutting activities among the OSELS divisions. The number of divisions will decrease from 10 to 4, and the branches will decrease from 24 to 13. The new divisions will be: Surveillance and Informatics, Workforce Development and Scientific Education, Laboratory Practice and Standards, and Analytics and Systematic Reviews. These changes will lead to more efficiency, reduced duplication, and better communication.

Dr. Cardo shared the current priority initiatives of OSELS and asked ACD for feedback on them, particularly regarding which initiative should be first. She noted that the initiatives reflect the critical cross-cutting activities of OSELS that was emphasized in the partner interviews. The initiatives are as follows:



- ❑ Increase the use of EHRs as part of an integrated strategy for public health surveillance. Partners indicated that there are too many systems, and they are not integrated or providing standards that public health and CDC should be using for surveillance.
- ❑ Improve public health data access, analysis, interpretation, and communication. CDC's data sets should be easy to find, and the user interface should be standardized.
- ❑ Lead the development of an efficient, sustainable, and integrated network of public health laboratories. This work includes the laboratory efficiency initiative and interfaces with external partners and CDC programs. Public health laboratories should be able to communicate with each other and with CDC, looking to EHRs in the future.
- ❑ Prepare the public health workforce to meet the challenges and needs of the future. OSELS also will place priority on the existing public health workforce, particularly in informatics.

OSELS will be part of CDC's coming challenges. They will work with the Office of State, Territorial and Tribal Support (OSTLTS) and with the Associate Director for Policy to engage programs. They have over-promised in the past, and they are committed to making positive changes, even by making "baby steps."

### Discussion Points

Dr. Goldman said that many ACD members are stakeholders of the work that OSELS does. She appreciated the careful approach to the reorganization and added that the office's priorities are sound. She expressed concern about the details, however, because each of OSELS's functions is critical. It is important to understand how those functions will map onto the new organizational structure. The operation should be more efficient, but not at the expense of those functions, some of which are labor-intensive. She observed that NCHS never seemed like a good fit for OSELS, as it has a different culture and different location, and asked for additional detail regarding how NCHS fits into the new structure. The data that NCHS provides are critical to public health.

Dr. Cardo shared the concerns about NCHS. The reorganization process includes meetings about strategic initiatives, emphasizing accountability and trust. They are establishing concrete goals across OSELS, taking into account how they will engage other programs and partners. In learning about NCHS and its placement in OSELS, she and her team felt that combining all of the program offices to one OD, with NCHS as the other entity represented in the OD, was the best approach. There are significant opportunities for working across OSELS and being "one." When she visited NCHS, she was impressed with their commitment to working together and moving forward together.



Dr. Farley encouraged OSELS to invest as much as possible in EHRs for public health surveillance. This issue is critical. In New York, they are progressing to a point where all EHRs will have standardized elements that can be aggregated at a state level. There are many ideas for how that pooled data can be used for surveillance, and the area will continue to expand. CDC's focus on this issue will help the entire country and will shape the surveillance system of the future.

Dr. Cardo agreed and noted that some projects are being stopped or suspended in order to focus more personnel and resources on EHRs and on ways to help health departments that may need platforms to take advantage of EHRs and their potential.

Dr. Chu agreed with the approach to consolidate oversight in OSELS. He also encouraged OSELS to focus on using EHRs and the "data explosion" that can be used for better overall surveillance. With the new information on big data analytics, the focus tends to be on the idea that more information is better, rather than on narrowing the focus. It is important not to be so overwhelmed by information for which it is not possible to determine what is signal versus a noise. One of the challenges associated with EHRs is that the information has to be in a useful format; however, it is unlikely that the country will homogenize its reporting systems. If the only data sources considered are the ones that can feed into a given set of fields, then the net is probably not being cast wide enough. He suggested that OSELS determine how to use the tools of big data analytics to sweep potential databases and learn whether there is a meaningful pattern. A unified office may be needed to assess what the different data sources, including primary care, medical homes, health plans, and laboratories, can contribute, and how to use the information in a smart and progressive way.

Dr. Fleming agreed with the approach to collapse OSELS into smaller divisions and to reduce overhead in the OD. Due to its cross-cutting nature, it is important that everyone in OSELS understands not only what they are tasked to do, but also what the rest of the entity is tasked to do. He suggested that in light of the reduction at the OD level, OSELS carefully define the job descriptions of the division directors so that there is a clear expectation and accountability for cross-communication across the divisions. The new structure makes it even more important that the division directors know what their counterparts are doing, and to look for opportunities for synergies. He reflected that as a practitioner, he observes that many in the field look to OSELS for good data about public health problems, and increasingly for information about solutions to those problems. The analytic elements of OSELS, such as the Community Guide, are not clearly reflected in the current priorities as presented. He emphasized that someone in CDC must ensure that there is integration and clear access not only to proven practices through the Community Guide, but also to emerging practices.

Dr. Cardo replied that the OSELS OD will serve as the structure that he described. The divisions need support and a way to integrate their work. The OD is not only focusing on external functions, but also is serving to lead the divisions. She agreed that the Community Guide and the Morbidity and Mortality Weekly Report (MMWR) are vital CDC products.



Dr. Henning applauded the reorganization and noted that the previous structure was unwieldy. Now the group is organized so that they can engage in more cross-cutting work. She encouraged OSELS to pursue innovation. Certainly innovation is occurring, but it does not always “rise to the top.” CDC’s competitive advantage lies in its innovation, especially in epidemiology.

Dr. Isham praised the emphasis on better data sources, particularly EHRs. He commented on the opportunity to create information from existing data and new sources. The “Health of the United States” report may not help states understand their individual states or sub-state levels, and information is not presented clearly on federal websites regarding Healthy People goals and other health-related items. In health delivery, work is ongoing regarding the “triple aim,” one dimension of which is health. He recently attended a workshop on creating scorecards for health. He has not observed the creation of information that can help feed that work in a readily accessible manner. The information could be created and presented more simply to be communicated to the country in a manner that reinforces the National Quality Strategy (NQS) as well as the National Prevention Strategy (NPS). It is not easy to understand the relationship between data outputs from the CDC and those initiatives.

Dr. Benjamin observed the potential for a bottleneck when reorganization involves consolidation. Much of this bottleneck is perceived, but it should be handled quickly. It would be helpful to create a user’s manual to communicate the differences in the new structure from a user’s perspective. This guiding piece will help people understand how to utilize OSELS and its resources. Currently, people have direct and indirect ways to reach CDC programs, and the new structure will change those pathways, which could be frustrating.

Dr. Richardson endorsed the critical importance of EHRs. She was glad that CDC intends to take a more active role in conversations about the data elements that are tracked, and how to build systems so that the most important information is tracked. HDS heard a presentation during its meeting from the Epidemiology and Analysis Program Office (EAPO) about the CDC Health Disparities and Inequities Report (CHDIR). HDS offered suggestions regarding making that information more accessible and easier to use, and therefore more valuable. The function of engaging programs across CDC and helping them to organize the information through a health equity lens will provide data that can be considered over time, across communities, and across groups. This function is critically important and should not be lost in the reorganization.

Dr. Greenberg observed that ACD members recognized the importance of the reorganization. He asked how ACD could be most helpful as the process moves forward.



Dr. Cardo thanked ACD for the input, which validated some of CDC's thinking and also raised other issues. The reorganization is not a one-time issue, but is a quality improvement (QI) process. ACD's thoughts regarding important functions and communication issues are critical. In the future, ACD's input into OSELS's priorities and how they are being addressed will be important. OSELS should be responsive and accountable for ACD's comments. Regarding the bottleneck issue, she noted that the concern was held by many. Their goal with the reorganization is not to be a bottleneck, but a doorway and a means for making connections. Regarding the access of data and simplifying data outputs, she noted that CDC OD leadership is aware of the need to improve. OSELS can help in this area.

Dr. Frieden thanked Dr. Cardo for her focused work in ensuring that the unit achieves its intended outcome. Regarding Dr. Goldman's questions about NCHS's "fit" in the new organizational structure, he said that much is still unknown. In the previous structure of OSELS, there was not adequate collaboration and integration among the parts that were not NCHS. As new leaders come to NCHS and OSELS, it may be useful to convene an ad hoc group from ACD to address specific issues, such as EHRs or the integration of clinical and public health data. He hoped that Dr. Cardo and her staff could call on individual ACD members to vet ideas and ask questions.

Dr. Greenberg observed that GWG was involved in the creation of CGH and in its OI process and new organization. He asked about institutional learning and shared lessons that can be called upon when an area of CDC reorganizes. Any reorganization has similar issues with human resources, organizational strategy and structure, and the Management Analysis and Services Office (MASO) requirements, and they can learn from each other's successes and challenges.

Dr. Cardo said that one of the approaches to reorganization has been to bring people from within the agency to the task, rather than hiring outside contractors. CDC personnel understand what the agency should be doing and what the connections should be. They are not building something for themselves, as they return to their units after the reorganization is complete. She has learned from the reorganization of CGH and discussed how OSELS can help with the details of that implementation. CDC OD staff have provided excellent support.

Dr. Frieden commented that there was a substantial reorganization at CDC four years ago. This change "de-layered" the agency and the recent reorganizations represent a tweak of those efforts to find ways to work more efficiently and collaboratively. Some areas of the agency are making minor structural changes as opposed to significant renovations. As a rule, there must be a strong case for reorganization. It is disruptive and time-consuming, and it can cause anxiety among staff. MASO has been helpful and supportive of these changes.



### **Current Issues: Public Health/Health Care Collaboration**

Mr. Andrew Rein (Associate Director for Policy, CDC) provided ACD with an overview of the collaboration between public health and health care. Now is the time to capitalize on the opportunities to collaborate presented by the implementation of the ACA and delivery system reform.

These opportunities are affected by a number of factors. Fiscal, accountability, and quality pressures are bringing change. State and local public health departments have lost 45,000 jobs, and there is pressure to find new partners and new ways to do business. There is pressure on the health care system to “bend the cost curve.” The health care system is looking for new ways to deliver results, and there are new levels of accountability for public health, which must show its value. The ACA brings coverage for millions more people, changes in the delivery system, and new ways for public health to understand its role in safety net and critical services. Payment changes, new models of care, and accountability changes all drive a desire to collaborate. The delivery system is evolving. Practices are consolidating, risk is shifting, and all- and multi-payer initiatives are evolving. These delivery system changes and growth in HIT bring new possibilities.

“Collaboration” represents an umbrella for public health and health care to work together. Sometimes the two align, as in the Million Hearts Initiative. Sometimes, the two work in parallel. Sometimes they integrate their activities through financial systems, accountability systems, and organizational systems. As the system evolves, they will move toward more integration. It is important to invest in the best of both systems and to look broadly.

There is great momentum in this area. With HRSA, CDC commissioned an Institute of Medicine (IOM) report, Integrating Primary Care and Public Health. This report spawned new thinking and new products, such as the Association of State and Territorial Health Officials (ASTHO) Primary Care – Public Health Strategic Map; the IOM Population Health Roundtable, co-chaired by ACD member Dr. George Isham; the de Beaumont Foundation Playbook and Meeting, which provides a practical guide on how to collaborate; National Association of County and City Health Officials (NACCHO) and American Public Health Association (APHA) activities; and a CDC-hosted cross-sector meeting. It is challenging to coordinate all of the activity, so that they have a symphony and not a cacophony.

Important areas for public health/health care collaboration include data, services, and drivers. The collaboration should include bi-directional data exchange and use. Public health should use clinical data, such as reporting of communicable diseases and immunizations, and should also use EHRs for surveillance. Public health can enhance surveys to better monitor health care access, utilization, and affordability in this evolving environment. Public health can also evaluate preventive services, such as screening. Since cost-sharing has been eliminated, this work can monitor its effects on care. Clinical use of community data and population health measures will represent a “feeding back” of data to drive quality improvement. A partnership with CMS has led to hospitals’



integration of the NHSN into their operational flow and reimbursement systems. Standardizing measures across systems will help drive the clinical system toward population health measures and validation.

Services are an important area for collaboration. High-impact public health services that protect the community, such as immunization, show public health's value in "getting outside the clinic walls" for service delivery. Public health must think about its collaborative role to ensure quality, continuity, and capacity. Turning people away is difficult for public health, and an approach that allows state and local entities to bill the system for providing immunization will be beneficial. It will build the culture and structures to allow for collaboration in other ways. Public health has not traditionally thought of itself as a reimbursed service provider, but it may build that capacity in certain ways. Public health must identify its clinical services with maximum health benefit and broaden the use of non-clinical providers. For example, community pharmacists can be strong partners in ensuring adherence to hypertension medications. Linked community and clinical services and activities, such as the Diabetes Prevention Program, are examples of purchasers, payers, and providers working together.

Drivers of public health/health care collaboration include guidelines, regulations, and incentive systems. The CHNA process has provided an opportunity to learn the best ways to work upstream with the IRS, as well as the best ways to work on the ground to provide TA and information-sharing. Accountable Care Organizations (ACOs) are required to follow more population health measures. Clinical guidelines from public health, such as those provided by the Advisory Committee for Immunization Practices (ACIP), encourage or require the clinical care system to deliver high-quality services.

It is important to improve the mutual knowledge between public health and health care professionals. Health care professionals often do not understand what public health does or the value of public health. Public health professionals may consider health care to be "messy" and to have a different incentive system. Mutual understanding will yield opportunities and the best solutions that may lie between the systems. Public health should understand health care finance and delivery, as well as the economic and budgetary analysis of community prevention. Return on investment (ROI) to health or society may not help a finance director or Chief Executive Officer (CEO), but they will understand a case that is made in economic as well as health terms.

A third driver of public health/health care collaboration is strategic partnerships. CDC convened a group of professionals from ACOs, which helped CDC learn about their current incentives and the energy that drives changes in their system. Public health can join ACOs as that system evolves. Spending time with purchasers, payers, and providers enriches all groups. CDC has a strong relationship with CMS. CDC has had a good relationship with CMMI, and the Health Care Innovation Awards have brought an opportunity to collaborate and for CDC to contribute to their work. This collaboration led to CMS asking CDC to manage the population-health related awardees, and the relationship continues. CMMI's State Innovation Model (SIM) initiative represents an



opportunity to consider how comprehensive delivery reform can take place. CDC helped evaluate the applications, and OSTLTS is helping provide TA to the grantees.

Every area of CDC is actively involved in the public health/health care collaboration. It is important to align and focus that energy. CDC's next steps will include how to prioritize the specific activities as well as its role within the system. CDC must advance high-value activities that will yield the greatest value and results. Internal coordination and tracking is critical to moving systems forward and to share lessons learned. Further, CDC must build capacity internally and in the field, as well as coordinate with external efforts. Communication includes external feedback loops to guide priorities.

To guide future discussions, Mr. Rein proposed an ACD Public Health/Health Care Collaboration Workgroup to advise CDC on priorities, high-value collaboration opportunities, and how to advise the field on strategic partners and processes. The group could include federal partners, state and local partners, and non-governmental partners, as well as other experts within and external to the ACD. These conversations must include the "health department of the future," financing, and services that public health should provide. Other important areas to consider include activities that will have the greatest impact and how to move forward through obstacles. He suggested that the group's purpose could be:

*To provide a structure to allow external leaders from the public health and health care sectors, including health care purchasers, payers, and providers, to advise the CDC and its Director regarding the highest impact opportunities for CDC to engage in the rapidly changing health system.*

The group's charge could include the following:

- Advise on the highest value collaboration opportunities with the health care system
- Advise on priorities to lead and assist the field in specific activities
- Advise on strategic partnerships and processes to move the field forward
- Consider time-bound recommendations (e.g., six-month, one-year, four-year)

### **Discussion Points**

Dr. Farley was encouraged by the positive tone of Mr. Rein's presentation and the movement in the right direction. Public health is good at measuring and driving quality, but a bigger driver for the health care system will be cost and cost containment. Public health sometimes assumes that improving quality reduces costs, but that assumption may not always be true. CDC could contribute by helping to develop systems and QI initiatives that measure cost and cost reduction as an explicit and common outcome. Public health should not shy away from the goal of reducing costs, especially given that many government expenditure problems are due to runaway health costs. This work is difficult, as costs are measured differently and the systems are fragmented.



Dr. Bal suggested that CDC could communicate through NACCHO and ASTHO to help state and local health departments understand that this collaboration is “the wave of the future” so that public health does not miss opportunities. He also suggested building the work on the concept of “data, delivery, and drivers,” which is easy to remember. CDC has in-house expertise in data, delivery, and drivers. CDC could create a package to help guide the field. Many hospitals do not know how to conduct a CHNA, so an entire industry has been born to conduct CHNAs and to learn what the data, delivery, and drivers are. CDC could naturally use its expertise to guide these efforts.

Dr. Isham appreciated the good work so far and the direction for future work. He noted the way that Mr. Rein framed the data and measures, particularly the clinical use of community data and population health measures. The two-way approach will be beneficial. He further praised the focus on clinical services with maximum health benefit. The care delivery side needs this information to address health behaviors. He wondered if clinical services could be ranked by health benefit and publicized. Information about where public health and care delivery make impacts could be a major driver. How does health and better prevention fit with achieving the triple-aim of the NQS? CDC can articulate the health status of the US as a whole and by state and community, and how that information can fit into the NQS framework. How does the NPS work with the NQS from the care delivery standpoint? There are several opportunities for CDC to rework or modernize its outputs to create an environment that drives both public health and care delivery, as well as provides a rationale for why they should work together.

Dr. Richardson agreed that CDC can make an enormous impact as the health system is transformed. It is important to make EHRs and medical care data available to public health. This work will not be easy. Hospitals and clinical practices use different systems that do not necessarily communicate with each other, much as the different surveillance systems at CDC do not communicate with each other. The same obstacles that have prevented CDC from reforming its own data systems are present in the medical care system. CDC may not have had these skills in the past, but should cultivate them now. CDC could play an important role and see how changes will impact CDC’s reporting systems and how the agency obtains data. Obtaining data directly from clinical systems in real time would be preferable to using reports that are filed sporadically and incompletely. CDC can also have an impact in prevention and the evaluation of prevention. CDC is the preeminent scientific authority on prevention and can perform systematic reviews to identify measures that are proven to be efficacious and to quantify that success financially. There is a great deal of confusion about prevention. For instance, many screenings are viewed as being prevention regardless of their efficacy or cost-effectiveness. This approach leads to literature concluding that prevention is not cost-effective. If CDC exerts authority in this area and provides solid evidence about efficacy and cost-savings, then it will improve the field significantly. The system will be awash in data because of the CHNAs and the increased availability of population data of all kinds. The system is missing intelligent interpretation of the data. Population data, demographics, and trends are complicated. CDC and its partners can provide scientific authority and guidance.



Dr. Fleming applauded CDC's leadership and observed that ACD is interested in helping the efforts move forward. He noted that the amount of time ACD workgroups can spend functionally and productively on issues is limited. These issues are vast, broad, and important and may not be suited to a workgroup structure. They may inadvertently create a process that is not as rapidly-moving as it needs to be. He suggested creating a task force to generate the tasks that should be addressed, prioritizing the areas that need work and noting where efforts at CDC and elsewhere are addressing them. The task force could then create a clear, focused, and achievable charge for an ACD workgroup.

Dr. Chu said that he had always been uncomfortable with the divide between public health and care delivery, because their ultimate goals are about the health of the entire population. Attention is focused on this relationship, but people do not know how to take the next steps, even though the framework and the funding exist. Prioritization is important. The issues should be framed so that anyone can understand them. It is also important to demonstrate the value of the steps. Opinions vary about what outcomes should be (e.g., lower cost, higher quality, or other measures), but value must be demonstrated. A number of groups are working on these issues, with IOM workgroups and collaborations across the US Department of Health and Human Services (HHS), and any of these groups could contribute to defining key outcomes, with input from payer and provider groups. The outcomes could then become key drivers for concrete steps to take in the immediate sense and in the longer term. CMS has done similar work as it has instituted value-based purchasing. The CHNAs will provide more information. He offered the example of Kaiser, which focuses on keeping its population healthy. They still need to work upstream, as they currently focus on one-on-one interactions that add up to a healthier population. They need to reach upstream to the built environment, influencing healthy eating and physical activity, and influencing schools to build fundamentals for better health across generations.

Dr. Richardson agreed that the emerging collaboration between public health and health care is important. In the clinical realm, the Health Information Exchange (HIE) is an example of "systems talking to each other." As HIEs allow clinical data to become poolable, and community data become available, CDC can look at information from both systems in innovative ways to inform public health and health care delivery. She encouraged the idea of CDC providing TA, as the agency can offer a great deal to assist institutions as they conduct their CHNAs to ensure that they are meaningful and lead to useful action. Public health could define what is unacceptable, as well as what is valuable. CDC can have a major impact on the care delivery system in this area by defining clinical interventions that are of value. With its emphasis on promoting health rather than treating disease and on evidence-based practices, public health has a great deal to offer care delivery. Public health also applies health equity. These and other important lessons come from CDC's scientific authority and can influence the way the care delivery system is transformed. CDC should be strategic about these opportunities. CDC can serve as a convener, assembling groups, agencies, and institutions together that may not come together otherwise.



Dr. Bal said that CDC should lead TA for CHNAs, just as it led TA for communicable and chronic diseases. The CHNA industry has created commercial entities, and other agencies are also becoming involved. For instance, the National Institutes of Health (NIH) is using community-based participatory research (CBPR) and disparities as drivers to help CMS and others become involved in CHNAs. This issue is clearly within CDC's purview, and there is urgency behind it. CDC can create models for this work in-house and then convene a focus group of outside individuals from the field and other partners to review the models. The CHNA is a means to an end, but public health has been bypassing the process. If public health does not define the community's needs, then it will not be involved in the implementation process.

Dr. Benjamin agreed that ACD should create a focused workgroup on these issues. He commented that "public health is on the menu, not at the table." The country is suffering from the lack of a definition of population health. The medical care community has a different understanding of population health from the public health community. The medical care community needs help conducting health assessments and evaluating policy, but does not approach public health. While little of CDC's work is directly clinical, the agency's work has enormous influence on clinical outcomes. An ACD workgroup could focus on population health as defined by public health. Because of its population-based perspective, CDC has the most important rights to these issues, and should take the lead to make sure the efforts are not executed in piecemeal fashion.

Dr. Botchwey said that one of public health's powers in CHNA is the scaling from individual-level interventions to population-level interventions. She has been working on issues concerning health data at the local, neighborhood level. There is a great deal of health data at the county level, but health changes do not necessarily occur equitably across counties. Because health data are not available at local levels, it is not possible to target interventions. EHRs, information from state health departments, or new collection approaches could advance data at these levels. Data consistency is another issue. It will be important to compare CHNAs to each other and to create a clearinghouse for the reports. There should be a benchmark or rating system for the CHNAs. Otherwise, there will not be a way to enforce or determine their value and understand whether they will have an impact. CDC should be involved in this work, but other groups such as schools, planners, and businesses should participate as well, given that they are members of the community who will help implement the benefits.

Dr. Greenberg observed that the ACD shares a passion for these issues as a top priority for the health of the US public. He asked about the human resources and structures that CDC has deployed to address the issues.



Mr. Rein answered that CDC's central policy office is small, but all areas of CDC are involved in these issues at some level. The Policy office will coordinate and provide leadership. Focus and grounding are key, and it is important to share concrete activities that will have impact. CDC has a leadership role in providing TA, but they need to take care because many activities are already underway in the field. CDC will not be effective if it adopts a "heavy hand," and the job is too large to undertake alone. CDC's leadership could take the form of guidance and steering, providing TA and science, as opposed to being proscriptive. He agreed that cost analysis needs to improve. Public health can articulate its health value and societal ROI, but the health system has a budget to work with, and public needs to address benefits, costs, timing, and "pocket problems." CDC can understand and identify values to different partners. They are engaging in a "life cycle" activity, building relationships and programs to move upstream as quickly as possible. Regarding the CHNAs, they are hospitals' regulatory requirement and are funded by hospitals. There are examples of hospitals working collaboratively with their communities and public health entities, putting community benefit dollars in upstream activities. They need to be flexible, perhaps by having a "backbone" for the funds. Work to rank clinical and health services is underway. Work is also ongoing regarding aligning the NPS and NQS.

Dr. Frieden thanked ACD for their observations and pointed out five key suggestions that he had gleaned from their discussion:

1. Collaborations at the federal level are important. There is a variety of partners, but CMS is the most critical. It is important to build this relationship collaboratively. In many areas, CMS pays private contractors to conduct their data analysis. CDC could do this work and also build capacity. For instance, CMS pays a private contractor for HAI work, but CDC would encourage state health departments to conduct this work to build capacity and improve performance. Agencies at the federal level can model interactions that could be possible at the state level.
2. EHRs are central to the public health/health care collaboration. This work is extremely difficult. For instance, electronic laboratory reporting seems like it should be easy, but it is enormously complicated, expensive, and cumbersome. In the universe of EHRs, CDC should define what it is trying to accomplish and determine the agency's role in improvement.
3. Individual programs at CDC have begun work on the central issue of defining value. The Million Hearts Initiative is an example of this work, as it is the top-value intervention for health care. Finding a common currency for value, be it lives or costs, is challenging. The agency is not expert at proving that its work reduces costs; it is expert at proving that its work saves lives. People who live longer can cost more in healthcare, pension, and Social Security costs. Some of CDC's work leads people who need care to it, which increases costs.



4. CHNA work is essential. CDC has a document in the clearance process, but the agency can think more broadly about packages and information that address standards for the assessments. These technical packages could establish potential interventions and outcomes for health problems in given catchment areas. There has been a vacuum in providing focused leadership in these areas, and CDC's products such as the Community Guide can provide a "menu."
5. Dr. Frieden could not envision dollars coming to upstream programs from the health care system. There are examples of such efforts, but it is difficult to think that the clinical system will fund basic, primary prevention measures, even though that support would be in their long-term interests.

Dr. Bal said that CDC's assistance with CHNAs may lead to more upstream dollars from the clinical system and would be the most valuable contribution that the agency could make to state and local officials.

Dr. Chu did not discount the possibility of upstream dollars from the health care system. With a technical package of programs that will have an impact, communities will be able to focus and not feel like they are doing the work on their own. Different people and groups, such as employers and community groups, are clamoring for total health and healthy workforce initiatives. The technical packages could also build capacity at local health departments, which could serve as conveners of the disparate interests. Moving upstream combines classic public health and community development efforts with economic development and socioeconomic support. This work could be stimulated by a technical package and capacity-building at local health departments.

Dr. Richardson agreed and indicated that she is not pessimistic about the possibility of the care delivery system looking upstream. Communities and employers, especially those that self-insure, are open to these efforts. CDC can shine a spotlight on successful examples of this work. Employers have great interest in the many benefits associated with improving employees' health, including reduced turnover and absenteeism. These trends will build.

Dr. Palacio added that there are opportunities for upstream movement within CDC's existing partnerships. The work needs to occur at the ground level, but CDC has upper-level opportunities to influence the rules around reimbursement, working with CMS to change the incentives in the system so that they better align with, and support, upstream work. CDC can also serve as a convener at the federal level. CDC can reach out in a community-development role, working with agencies that implement the banking rules in community development, for instance, and aligning banking incentives with healthcare reimbursement incentives.



Dr. Fleming added that with Medicaid expansion, a large number of people will be seen by the system who have underlying individual determinants of health, including problems with housing, transportation, and employment. It will be in the best interests of the health care system to think about solving these problems on an individual level, which represents a small step upstream. Those individuals may come from the poorest parts of the community. If those individuals are also the most ill, then investments in communities may be in the best interests of the delivery system as they consider “community hot-spotting.”

Dr. Farley said that cost should not be left out of the formulation of value, even if cost should not determine where public health’s efforts go. Certain things save lives and save money; certain things save lives and cost money. CDC is the best-suited group to make that case. If the healthcare system will not contribute funds to population-based prevention, it can still contribute political power and support.

Dr. Botchwey emphasized the power of interdisciplinary collaborations at the federal, state, and local levels. Local health departments are critical conveners and can translate health benefits and goals to other collaborators from other disciplines. These collaborations will bring considerable leverage.

Dr. Frieden thanked the ACD and expressed his appreciation for the group’s interest and helpful guidance.

### **State, Tribal, Local, and Territorial Workgroup Update and Discussion**

Dr. David Fleming (STLT Workgroup Chair) provided background on the STLT Workgroup, which has been working for the past year on its charge to identify the most important priorities for state, local, tribal and territorial health departments as they become 21st Century health departments. During the last ACD meeting, the workgroup presented a series of recommendations that were approved by the ACD. The recommendations fell into the following categories:



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- Clinical Healthcare and Public Health
  - Assist health departments to better implement community benefit.
  - Assist health departments to work with EHRs.
  - Provide federal leadership in working with CMS and HRSA to increase the ability of health departments to link to funding streams.
  
- Core Services in Public Health
  - Assess current practice and thinking regarding the “package” of services provided by health departments.
  - Create a process to help guide health departments in talking to policymakers at the federal, state, and local level regarding their needs.
  
- Shared Services/Regionalization
  - Develop a clearinghouse of program practices and models.
  - Identify federal ways to incentivize better use of shared services and regionalization.
  - Work with groups convened by other entities that are engaged in shared services.
  
- Workforce Development
  - Address vital gaps in the public health workforce.
  - Redesign the core competencies needed in 21st century health departments.
  - Grow partnerships between the public health workforce and clinical care.
  - Realign public health school curricula to prepare students for current and future health department needs.

Dr. Judy Monroe (Director, OSTLTS) provided an update on progress made on the recommendations since October 2012. OSTLTS convened four working committees and a steering committee, with representation from across CDC at various levels, to address the recommendations.

Regarding the recommendations related to community benefit, efforts are under way to coordinate agency-wide efforts that provide TA and guidance to health departments. Multiple parties in NCCDPHP, OSELS, OSTLTS, and OADP are involved. Leadership at the health department level is critical to community health needs assessment (CHNA) especially in working with non-profit hospitals to implement the IRS requirements that grew out of ACA. Accreditation of health departments is also driving the field toward collaboration for health assessment and improvement. The agency is identifying emerging best practices as communities and health departments are driving community benefit work. A website to link agencies to health assessment and improvement tools that will be part of the STLT gateway is in CDC clearance. The site includes tools, access to data, and other resources for health departments that are ready to engage in the community health assessment. OSTLTS held an over-subscribed training that covered the topic this week, and they are responding to interest in the field. Further, OSTLTS is exploring ways to help communities pursue the intentional investment of savings from value-based purchasing and other community assets into upstream determinants of health.



Regarding incorporating public health into financing models, Dr. Monroe emphasized that CDC enjoys strong collaborations with HRSA and CMS. CDC and HRSA are considering joint Funding Opportunity Announcements (FOAs). On April 1, 2013, 25 states received funding from CMMI. OSTLTS and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) are involved with CMMI-funded State Innovation Model (-SIM) awards. Sixteen of the states are design states that have six months to design their all-care, integrated systems. They are focused on saving costs and on improving health. OSTLTS is working with all 25 states, but is focused on the 16 design states. Their mission is to ensure that public health will be “at the table.” Working with ASTHO, OSTLTS helped ensure that the state health officers or their representatives will attend the National Governor’s Association meeting in May 2013. OSTLTS is also working with CMS on the proposed rules allowing payment to non-clinical providers. CMMI looks to CDC for education on population-based health. CDC provides tailored TA to states and also provides webinars on broad issues.

OSTLTS has begun to respond to recommendations regarding core public health services in several ways. They recognize the need for common terms (e.g., foundational services/capabilities, core services, basic services/programs, etc.). They are in the process of determining current thinking and engagement in this work at the national as well as state levels, including learning about legislation in some states that use language around core services. Based on the information that they gather from the field and from cross-walking core services-related recommendations from existing reports, OSTLTS will engage in a stakeholder process in collaboration with other partners, as appropriate.

Regarding shared services, the Robert Wood Johnson (RWJ) Foundation-funded Center for Sharing Public Health Services (CSPHS) created a “Spectrum of Cross-Jurisdictional Sharing Arrangements” framework, which OSTLTS is utilizing in the way CDC collects information on sharing services. OSTLTS anticipates developing a clearinghouse of web resources on the STLT gateway in collaboration with CSPHS in order to avoid duplication. The web resources will include an explanation of myths and realities regarding legal barriers to regionalization and shared services as well as examples of cost savings. The CDC FOA process has been standardized, and OSTLTS is looking within that structure to find mechanisms that will foster shared services and regionalization. They are aware that they need a marketing plan for the tools that they develop.

ACD’s recommendations regarding the public health workforce, a roadmap for the National Public Health Workforce Strategy has been developed, under the leadership of SEPDO/OSELS. A summit was convened in December 2012 to consider the workforce needs, and the information from that summit is informing the strategy. CDC has strengthened its relationship with HRSA regarding workforce as well.

CDC has consciously redesigned how it trains field personnel and entry-level personnel. A 101, basic curriculum has been developed for entry-level public health professionals



on core public health sciences. There are plans for instructor-led and e-learning versions of this curriculum, depending upon funding availability. CDC is also further standardizing and improving training of project officers across the agency. A common Learning Management System is being put in place, and a pilot “training-in-place” program will develop the skills of existing workforce in STLT health departments in EHRs.

To improve the public health workforce and health care system partnership, OSTLTS has expanded on its Primary Care Public Health Initiative (PCPHI). This initiative was designed to magnify the impact of Vital Signs and push it to residency programs. The DeBeaumont Foundation and Duke University along with CDC are developing a practical online interactive “playbook” to facilitate integration of public health and primary care. EIS officers and fellows are focusing on the intersection between public health and healthcare. Because of its work with residency programs and practicing physicians through national associations, CDC is finding opportunities to integrate and influence the necessary milestones for every resident to include population health. Professional organizations are eager to work with CDC on this issue. They are also working to incorporate population health approaches in the maintenance of certification. Through longstanding cooperative agreements and relationships with national associations, CDC is working toward including more practical curricula in population health.

Regarding the ACD recommendations on EHRs, OSELS has discovered a need to better understand and address internal barriers to optimal use of information technology at CDC. They also need to build relationships with the health care industry, particularly with partners that define the data before it is collected. CDC is moving toward leveraging new technology, such as the Cloud. This work can lower costs and create a reusable platform for the data. Another priority is to provide shared data services to lower the bar for EHR use. OSELS is also working at all levels of leadership and programs to identify solutions to improve implementation.

As one anticipated resource that should help move EHR sharing across clinical care and public health, OSELS has established a Chief Public Health Informatics Officer, which promises to make a significant difference in the EHR work and is set up to ensure accountability. The agency is also focusing on system integration among CIO programs. As part of efforts to improve data sharing, CDC received Certification and Accreditation and Authority to Operate (ATO) for the CDC Platform that will provide National Notifiable Diseases Surveillance System (NNDSS) data to CDC Programs. For surveillance support, OSTLTS provided an Internet entry point for finding available surveillance data sets and resources.



### Discussion Points

Dr. Goldman suggested that in aligning public health school curricula, working with professional organizations and associations of schools of public health may not lead to actual interactions between CDC and the schools of public health. Now is the time to work in this area, because curricula need to change to reflect rapid changes in the field. Relationships are changing because of structural and funding changes. For instance, HRSA funding for the Public Health Training Centers has been reduced to about 10% of the current funding levels, so HRSA may not be the strongest partner in this area.

Dr. Botchwey stressed that the conversations regarding accreditation and core competency training are important. These conversations are talking place not only in public health, but also in architecture, planning, and other fields, which are training students to recognize the value of public health and its function. Columbia University is reshaping its public health program and curriculum to incorporate social determinants of health. There is also support from the NPS, which has led to conversations among leaders across different fields to consider interdisciplinary approaches to accreditation and core competencies. It is important to reach not only students in the pipeline, but also the current workforce. For instance, personnel at the Environmental Protection Agency (EPA) need to take on more public health work, and they do not know how to do it.

Dr. Chu noted that just as universities are moving toward offering more courses online and the Institute for Healthcare Improvement is conducting virtual patient safety training, a modular core curriculum could be developed and put online.

Dr. Richardson said that the work with residency programs and healthcare providers is interesting. The maintenance of certification process has potential, and she encouraged CDC to look broadly across the healthcare provider spectrum. All medical specialties, not just primary care providers and residents, should have requirements for milestones and systems learning, bringing opportunities to inform all health care providers on how to infuse the public health perspective into their training programs and through the maintenance of certifications. Re-training the existing health care workforce represents an important way to approach the public health / health care delivery collaboration. The professional organizations and societies that administer Continuing Medical Education (CME) programs are potential partners in tailoring existing training programs.

Dr. Bal suggested that health departments could be rated or ranked in the same manner that hospitals are ranked by the CHNA. Many hospitals have bypassed health departments in the CHNA process, but in some cases, state and local health departments have been passive and have not participated in the program. Ranking health departments would help all players in the process.



Dr. Fleming acknowledged the efforts of past and present members of the STLT workgroup. He congratulated Dr. Monroe and CDC for taking the recommendations seriously. It was heartening to see each of the recommendations backed by a committee and concrete action steps. This work speaks to the strength of the ACD and its relationship with CDC and OSTLTS.

Dr. Greenberg thanked Drs. Fleming and Monroe for their leadership and indicated that ACD members with additional comments and questions should forward them to Dr. Monroe.

### **Ethics Subcommittee Update and Discussion**

Ms. Ruth Gaare Bernheim (Chair, Ethics Subcommittee) presented revisions to the mandatory influenza vaccine case study, based on suggestions from the previous ACD meeting. She thanked Dr. Drue Barrett, DFO for the Ethics Subcommittee, and ACD members Dr. George Isham and Ms. Sara Rosenbaum for their involvement on the subcommittee. She emphasized the Ethics Subcommittee's strong commitment to, and interest in, working with the ACD in whatever structure is most appropriate. Their recent work has focused on ethical issues raised by local public health officials.

Ms. Bernheim noted that at the previous ACD meeting, concern was raised about a comment at the end of the mandatory influenza vaccine case in the sample ethical analysis that pertained to the role that scientific uncertainty should play in the decision to mandate vaccination of health care providers. The Ethics Subcommittee suggested that the ethical argument for mandatory vaccines for healthcare workers might be undermined by the scientific uncertainty regarding its impact on nursing home patients. The ACD suggested that this stipulation might set the ethical bar too high in terms of the level of scientific justification that mandatory vaccine requires.

In order to address those concerns, the Ethics Subcommittee revised the last paragraph of the case study. It now focuses on the opportunity that the lack of scientific certainty provides to engage healthcare personnel at various levels in dialogues about alternatives. The dialogue can build trust among nursing home management and personnel as they discuss everyone's concerns. The case also addresses the role of professional obligation, qualifying that there are many types of personnel who provide care in nursing homes, and there is no standard level of professional training or professional ethic that applies to all of them. Appealing to professional obligations can therefore be problematic.

### **Discussion Points**

Dr. Frieden expressed confusion regarding the stated uncertainty of the scientific evidence and absence of a scientific mandate. The last time he reviewed the data, at least two studies showed that lower vaccination rates in health care providers in long-term care facilities was associated with higher mortality among residents of those facilities. This conclusion suggested that not vaccinating health care workers, whether the vaccination was voluntary or mandatory, placed residents at higher risk of death during influenza season. He asked about the CDC Flu Program's involvement in



development of the case study. He congratulated the Ethics Subcommittee on the interesting and thoughtful discussion, particularly in making the distinction between an employer mandating a vaccination and a professional society endorsing universal vaccination.

Dr. Barrett replied that the Ethics Subcommittee received input from subject matter experts from CDC's infectious diseases centers (NCEZID and NCIRD) as well as from the National Institute for Occupational Safety and Health (NIOSH). However, they can revisit the case with the Flu Program to learn whether new data are available.

Dr. Frieden pointed out that if there is clarity that lower vaccination rates are associated with higher death rates among residents, then that clarity would change the ethical discussion. From the standpoint of a public health practitioner, he has been pleasantly surprised by increases in health care provider vaccination rates, even without a mandate. This year, the rates were stratified by type of healthcare provider for the first time. Nurses, pharmacists, and doctors were vaccinated at approximately 85% rates, where nursing home and allied health staff were vaccinated at lower rates.

Ms. Bernheim said that the Ethics Subcommittee considered that science and changed the language to reflect that vaccination is warranted by the weight of the evidence. The ethical questions that may be raised by some stakeholders could focus on the effect of a mandatory requirement.

Dr. Frieden noted that pages 8 and 9 of the case study refer to "uncertainty of scientific evidence" and the "absence of a scientific mandate."

Dr. Farley said that New York State is adopting a rule to mandate vaccination for all health care workers, unless they wear a mask during influenza season. He disagreed with the way that the case study was presented and noted that the New York City Department of Public Health and Mental Hygiene feels that the weight of evidence is strong enough to justify mandatory vaccination.

Dr. Chu agreed with Dr. Farley and indicated that they have been trying to put such a mandate in place in California. It is difficult to make this mandate without authority, and he felt that this case study represents a regression and may detract from those efforts.

Dr. Chu noted that all ethical issues are grey rather than black or white. Assessing available evidence includes an evaluation of the potential for harm, the potential for good, the effects on private liberty, and obligations to patients. He believes it is reasonable to mandate either influenza vaccine or a mask. Taking this issue on as an ethical exercise should lead to a conclusion that drives toward the best interest of the greatest good.



Both Ms. Bernheim and Dr. Barrett noted that their goal with case studies is to lay out all sides of an issue and to explore the values and philosophical arguments that different stakeholders bring to the topic. Cases are not meant to be policy statements or recommendations.

Dr. Greenberg summarized that the case study would not be approved in its present form. He thanked Ms. Bernheim and the Ethics Subcommittee members for their hard work. Ms. Bernheim expressed her appreciation to the ACD members for their feedback.

### **Health Disparities Subcommittee Update and Discussion**

Dr. Lynne Richardson (Chair, Health Disparities Subcommittee) presented ACD with a series of recommendations for consideration from HDS. She reported that last spring, HDS members met with the IOM Round Table on the Promotion of Health Equity and the Elimination of Health Disparities regarding their work in policy- and systems-level approaches to those issues. As a result, a small group was convened to help HDS develop a series of draft recommendations to inform CDC's efforts to apply the "health equity lens" across the entire agency. Many actions in the recommendations are already being implemented within CDC. There is an effective Office of Minority Health and Health Equity (OMHHE), but all health equity work at the agency cannot be the responsibility of that office. Health equity is a cross-cutting issue that should be imbedded in every program and every center.

### **Recommendation #1: Develop a CDC framework for action to achieve health equity.**

A unified framework for action will inform how health equity is imbedded and integrated into all of CDC's work. The centers and programs that do this work well can help establish best practices. The framework can include standardized indicators, measures, and tools to monitor trends in health equity and should incorporate the use of evidence-based approaches. The framework can address the essential components that every CDC program should have to ensure that health equity issues are being addressed and clarify which organizational structures within CDC facilitate the integration of health equity. There are a number of models for this work across the agency, and some centers have offices or officers dedicated to health equity. Some of those structures may work better than others, and it is important to understand how programs are evaluating the effectiveness of their current operational structure in health equity. Additionally, the framework could help promote policies that support reducing health disparities and achieving health equity across CDC.



**Recommendation #2: Identify and monitor indicators of health equity.**

HDS heard a presentation about the CDC Health Disparities and Inequalities Report, which was released for the first time in 2011. This report is a seminal resource, with the 2013 report to be released soon. While HDS applauds the usefulness of having the data presented in a standardized way that allows for the evaluation of progress over time and across communities and programs, they also noted gaps in the data. Data on all of the topics were not available for all of the groups of interest. HDS suggested that a biennial report may not be the best vehicle for monitoring issues such as these. A different system that would allow for immediate updates when data are released may be more useful. HDS encouraged the development of data sources for all groups of interest, including racial and ethnic minorities; different language preferences; sexual orientation and gender identity; socioeconomic groups; rural and urban groups; and all groups that experience health disparities. These ideas link to the discussions about EHRs, including how to build demographic variables of interest that are known to be associated with health disparities into data collection systems by providers and other entities that collect data.

**Recommendation #3:** Promote a dual approach of implementing universal interventions and targeted community and clinical interventions in communities at highest risk to reduce health disparities and achieve health equity.

This recommendation embraces the dual approach of achieving health equity, which includes implementing universal interventions that affect the health of the entire community and targeted and culturally-tailored interventions. Those interventions may arise from community knowledge, best practices, or innovative and experimental means for gathering an evidence base. HDS laments the loss of CDC's Racial and Ethnic Approaches to Community Health (REACH) programs to budget cuts. REACH was effective at identifying community innovations at the local level, and at helping to produce an evidence base. REACH produced more peer-reviewed articles than any other program of its size at CDC. HDS hopes that the lessons learned from REACH will not be lost and that all of CDC's programs and centers will take up that evidence base and apply it to their work, incorporating initiatives for community capacity-building and the dual approach into other programs, such as the Community Transformation Grants (CTGs). As resources shrink, they need to be smart and resourceful to ensure that the work is done effectively.

**Recommendation #4:** Support the conduct of rigorous evaluations of this dual approach to establish best practices and evidence-based strategies to reduce health disparities and achieve health equity.

HDS supports rigorous evaluation of the universal and targeted approaches. For example, an intervention may be effective across a jurisdiction, but some groups could be unaffected by it. The dual approach applies in such a situation. Programs should be evaluated to ensure that there is equity of benefit across outcomes. Culturally-appropriate evaluation strategies may be needed to measure the benefit of the culturally-tailored and targeted interventions.



Recommendation #5: Build community capacity to implement, evaluate, and sustain health equity programs, especially in communities at highest risk.

HDS generated a list of things that CDC can do well to build capacity, such as providing TA and toolkits to help build community capacity to address social determinants of health; improving health literacy; building cultural competence in local public health workforces; and imbedding health equity into local communities to sustain health equity efforts after grant programs end.

Recommendation #6: Support training and professional development of the public health workforce to address health equity.

CDC should develop a diverse public health workforce and assure that both the newly-trained and currently-practicing public health practitioners have the skills, knowledge, and competencies that they need to achieve health equity in their work. CDC can play a role in this work through pipeline and continuing education programs.

### **Discussion Points**

Dr. Farley commented that despite a number of people working on these issues, there are few good examples of where health disparities have been reduced. Focusing on evidence-based approaches could be problematic if there is a lack of evidence of success. It is challenging to address the problems with the tools that public health has. He cautioned them about assuming that there is a group of evidence-based practices that CDC can disseminate to address these problems.

Dr. Goldman commented on recent changes in trends in data for birth outcomes. Some disparities are decreasing, which represents a “first ray of hope” and an opportunity to learn how to achieve health equity.

Dr. Farley agreed that the gap in life expectancy is narrowing in New York City, but they do not know why.

Dr. Goldman said that these trend changes should be studied, because it is important to know why they are changing. Academia could assess these issues, because practices that are effective in reducing disparities must be identified. Many disease rates are declining rapidly, but the disparities remain constant, or even increase, which is frustrating.

Dr. Richardson shared the frustration and noted that while there are no easy answers to these problems, they should still pursue the answers. The dual approach may represent part of the answers. The literature is growing regarding targeted, culturally-tailored interventions to address specific health and health care disparities. There are emerging strategies that are “moving the needle,” so the prospects are not too dismal. However, a great deal of work remains.



Dr. Chu reported that Kaiser captures racial and ethnic data for its nine million members on a systematic basis. Kaiser developed algorithms for this work because self-report is not accurate. The Kaiser population is largely commercially insured and approximately 5% – 6% Medicaid, so it is not typical. Because California is a diverse state, Kaiser can capture information about large ethnic populations. They have tracked disparities and observed some leveling of differences and reduction in disparities over time. There are probably databases that will support additional study.

Ms. Villar clarified that additional feedback from ACD would be incorporated into revisions to the HDS recommendations, which will be presented to the ACD for a vote at the fall 2013 meeting.

Dr. Frieden added that thoughts regarding specific indicators, such as studying positive examples, would be helpful. He agreed that the recommendations should not “paralyze” programs by suggesting that they should only implement interventions that have been proven, because that list may not be long.

Dr. Richardson indicated that HDS supports that approach and realizes that limiting work to evidence-based approaches would be restrictive, given that “there are not enough tools in the toolbox.”

### **Global Work Group Update and Discussion**

Dr. David Fleming (Chair, Global Work Group) summarized the previous day’s GWG meeting. He acknowledged the excellent work of CGH, particularly Drs. Pattie Simone and Anne Schuchat, during the leadership transition at the center.

GWG addressed many issues at the meeting and provided advice to CGH in three areas. CGH recently underwent an OI review, which was scheduled but was also in response to recent criticism in *The Lancet*. GWG praised CGH for its response to that criticism and to the recommendations from the OI review. Remarkable progress has been made in implementing the strategic plan and in developing outcomes and indicators as part of a process that might be useful to other parts of CDC. CGH is changing its organizational structure and combining two divisions into one. GWG provided suggestions to CGH in this area, particularly in providing accountability and including expectations for cross-cutting work in the job descriptions of the new division. Because so much progress has been made, the new CGH Director, Dr. Tom Kenyon, may opt to conduct a one-year post-OI report-out regarding the progress that has been made.

One of the concerns regarding CGH has been that much of CDC’s global budget is categorical. One of the core missions of the center, capacity-building, is therefore challenging. CGH shared examples of building capacity in laboratories in Africa, which fulfills a critical need and illustrates an example of bringing categorical resources together to fulfill a need. CGH also shared information about CDC’s work with National Public Health Institutes around the world. Many countries understand the value of having a “CDC” and are asking CDC for assistance in creating that capacity. GWG



suggested that state and local health department expertise could be drawn into this process and also could benefit from the expertise that CDC is gathering overseas.

The GWG meeting included in-depth discussion regarding the use of the word “security” and particularly “health security” in describing the work that CGH does. In this country, the phrase makes sense to many policymakers and is appropriate; however, members of GWG cautioned that using the phrase overseas may carry negative connotations.

GWG observed that usually during a leadership transition, the best that can be expected is a “firm hand on the rudder so that the boat still goes in the same direction.” In the case of CGH’s leadership transition, “the boat has speeded up.” Dr. Fleming remarked on the strong growth and transformation of CDC’s global work since the creation of CGH and due to the strong work of the center.

Dr. Tom Kenyon will provide direction regarding the next issues that GWG will address. There is intense interest among GWG in areas where cross-collaboration is required. The group is interested in following up on recommendations regarding coherent plans for TB. Additionally, noncommunicable diseases (NCDs) have always been on the agendas of CGH and GWG, and the group looks forward to moving those issues forward, albeit with limited resources. It will be important to continue to be creative in using resources to build capacity. This work can be difficult to justify to policymakers, but is critical at the country level.

### Discussion Points

Dr. Henning agreed that watching the progression of CGH has been impressive. She looked forward to meeting the new CGH director.

Dr. Greenberg commented on the strong rapport between GWG and senior leadership at CGH.

Dr. Frieden asked for additional detail regarding best practices that emerged from the development of CDC’s Global Health Strategic Plan.

Dr. Fleming answered that CGH put time and energy into creating the strategic plan, rather than viewing it as something that had to be done to satisfy a requirement. The center approached the plan as a tool that they would use to move forward. Additionally, there was an accountability aspect to the work. Specific workgroups with specific leaders were established, with definite timelines and deliverables. Each of the strategies in the plan includes specific measurements and targets. CGH has created an ongoing process to monitor progress toward reaching those targets. GWG suggested that the process should incorporate a means for identifying when progress is slowing, or an effort is going off-target, so they do not have to wait for an annual report to take steps to correct it.



Dr. Greenberg congratulated Dr. Simone for her personal responsibility and leadership in the creation and implementation of the strategic plan. She personally met with, and charged, each of the 17 workgroups that contributed to the strategy. This commitment will result in positive and measurable outcomes for CGH.

Dr. Simone emphasized that she and CGH feel extremely lucky to work with GWG. Their input is valuable and appreciated.

**October 2012 Minutes / Future Plans for ACD / Agenda Items for October Meeting**

During this session, the October 24, 2012 minutes were raised for feedback and a formal vote; Dr. Greenberg requested feedback regarding the meeting, including the seating arrangement; and agenda items were posed for the October 2013 ACD meeting.

**Motion**

Dr. David Fleming moved to approve the minutes of the October 24, 2012 Global Workgroup minutes. Dr. Kelly Henning seconded the motion. The minutes were approved unanimously, with no abstentions.

**Discussion Points**

Dr. Chu suggested that mixing the CDC senior staff and ACD members would facilitate better interactions.

Dr. Richardson agreed and added that having CDC leadership at the table fosters better conversation. She felt that flexible seating arrangements would be beneficial. Dr. Botchwey agreed.

Dr. Greenberg said that Ms. Villar and CDC staff would continue to encourage interactive dialogue as best they could.

Dr. Richardson commented that in-person meetings are more valuable than video teleconferences. She acknowledged financial constraints, but hoped that ACD and its subcommittees could meet in person so that they could take advantage of the valuable information that is exchanged and work that is accomplished when they meet together.

Dr. Bal agreed, noting that video conferencing equipment is not reliable.

Dr. Fleming observed that the format of this meeting allowed for more discussion and interchange, which is valuable in an in-person setting. Teleconferences can be useful for information transfer, but not for dialogue.

Dr. Greenberg hoped to operate in a format that is respectful of the need for subcommittee and workgroup updates while encouraging dialogue.



Dr. Frieden said that CDC has a mandate to reduce conference and travel costs. The agency has already reduced these costs by more than 50%. He will set a good example for this reduction at the Director's level. Adding a day to a conference is less costly than holding two conferences. He acknowledged that many workgroup members come to Atlanta one day in advance of the ACD meeting to meet and work on their specific issues, and he wondered whether there would be value in ACD members meeting with specific programs or groups to address specific issues on an individual basis.

Ms. Villar said that she and her staff can consider the year's budget and other proposed changes to find other ways to save costs.

Dr. Greenberg agreed that electronic means of meeting are effective for transmitting information, but are less ideal for dialogue and discussion. He encouraged creative solutions to this issue. He then asked ACD to engage in a thought process about the "35,000-foot issues" that are important and should be considered by the group. This process would serve as a mechanism for ACD members to suggest pressing public health issues to CDC leadership.

Dr. Bal suggested that ACD convene a workgroup or subcommittee to address the public health/health care collaboration issues raised by Mr. Rein's presentation. A group that works on these issues should include representation from all levels of public health, as well as hospitals. Progressive hospital professionals should share their perspectives, and less-progressive hospital professionals should also share their perspectives.

In the interest of time, Dr. Greenberg said that he would email the ACD members to gather their thoughts regarding emerging public health issues to bring to the committee.

Ms. Villar revisited the chart of ACD workgroups and subcommittees from the morning session. Considering the lunchtime training from MASO regarding workgroups and subcommittees, and FACA rules and regulations, she hoped that ACD would reach consensus regarding adoption of the recommendations. She added that if the STLT Workgroup were converted to a subcommittee, workgroups within the subcommittee would be formed to address specific activities and issues. They will continue to keep surveillance and epidemiology issues on the radar, especially as OSELS goes through its reorganization and as issues such as EHRs emerge.

Dr. Palacio wondered about the costs and benefits associated with converting the STLT Workgroup to a subcommittee. For instance, there is a burden associated with making all participants on a subcommittee a Special Government Employee (SGE), and she wondered whether potential members could be lost as a result of the requirements.

Ms. Villar said that she and Dr. Monroe discussed the issue, and there could be a natural rotation coming on that workgroup.



Dr. Monroe felt that the benefit of becoming a subcommittee would outweigh the costs. She observed that the members of the STLT Workgroup would “step up” to the added responsibilities associated with belonging to a subcommittee.

Dr. Fleming agreed and noted that people had been excited to participate on the workgroup. There was no shortage of individuals who were ready to contribute. Most members of the workgroup work in state, local, tribal and territorial health departments and have experience with government requirements. The ability to make specific recommendations to CDC and the ACD outweighs other considerations.

### Motion

Dr. Dileep Bal moved to approve the recommended changes to the ACD workgroups and subcommittees as presented by Ms. Villar. Dr. Lynne Richardson seconded the motion. The motion was approved unanimously, with no abstentions.

Dr. Bal raised the issue of a group to address the public health/health care collaboration, and whether the group should be a subcommittee or a workgroup.

Ms. Villar suggested that a workgroup might be the appropriate structure to begin the work. Mr. Rein agreed and said that the ACD had provided good feedback regarding how to start the activity.

Dr. Greenberg wondered whether the subject matter and number of issues might be more than a workgroup could handle.

Dr. Fleming observed the mismatch between the resources available for a workgroup and the task put before them regarding the public health/health care collaboration. He suggested that they create a workgroup to jump-start the efforts. The workgroup should have a clear focus and deliverables so that a large agenda will not overwhelm them.

Ms. Villar said that if they began as a workgroup, then the ACD could revisit the structure later.

Dr. Frieden observed that the first two orders of business for the workgroup could be to brainstorm potential areas of work and then to prioritize them.

Dr. Fleming added that focused tasks may be a good predictor of who the membership of the group should be over the long term.

Dr. Frieden asked for a show of hands from ACD members who would be willing to serve on the workgroup. All members of the workgroup, including Dr. Isham on the telephone, indicated willingness to serve on the group.



**Motion**

Dr. Dileep Bal moved that the ACD create the Public Health/Health Care Collaboration Workgroup, charged with the task of developing the future directions of the group. Dr. Georges Benjamin seconded the motion. The motion carried with no abstentions.

Dr. Benjamin volunteered to chair the work group.

**Presentation of Letter of Service to the ACD Member Rotating Off, Effective June 30, 2013**

Dr. Frieden thanked Dr. Kelly Henning for her years of service to the ACD. Dr. Henning was his EIS supervisor in 1990, and he appreciated her input and wisdom in global health and epidemiology, especially given her other responsibilities. He hoped that they could continue to call on her for advice in the future. Dr. Greenberg added his congratulations, and Dr. Henning indicated her pleasure at serving on the committee and working at CDC again after many years away.

**Public Comment**

Dr. Greenberg opened the floor for public comment at 2:42 pm. Hearing none, he proceeded to the last agenda item.

**Closing Comments**

Dr. Greenberg thanked ACD and CDC staff for the opportunity to meet. The meetings are moving in a more interactive direction, and he expressed gratitude to the leadership of CDC for working to facilitate dialogue. Ms. Villar thanked Dr. Greenberg for his involvement and leadership. Dr. Frieden thanked ACD for their time and their thoughtful advice. Their input is useful and helpful, and he appreciated their commitment to the committee. He echoed Dr. Simone’s observation that the committee may not recognize how important their contributions are, and how they help CDC see “beyond the trees to the forest.”

With no further business raised or questions/comments posed, the meeting was officially adjourned at 2:45 pm.



**Certification**

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 25, 2013, meeting of the Advisory Committee to the Director, CDC are accurate and complete.

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Date

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Alan Greenberg, MD, MPH  
Chair, Advisory Committee to the  
Director, CDC



**Attachment #1: Attendance**

**ACD Members Present:**

**Dileep G. Bal, MD, MS, MPH**  
Kauai District Health Officer  
Island of Kauai, Hawaii

**Georges C. Benjamin, MD, FACP, FNAPA, FACEP(E), Hon FRSPH**  
Executive Director, American Public Health Association

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

**Benjamin K. Chu, MD, MPH, MCAP**  
Group President, Kaiser Permanente Southern California and Hawaii  
President, Permanente Southern California Region

**Thomas A. Farley, MD, MPH**  
Commissioner  
New York City Department of Health and Mental Hygiene

**David W. Fleming, MD**  
Director and Health Officer for Public Health  
Seattle and King County  
Chair, Global Workgroup, ACD  
Chair, STLT Workgroup, ACD

**Lynn R. Goldman, MD, MPH**  
Dean, School of Public Health and Health Services  
Professor of Environmental and Occupational Health  
George Washington University School of Public Health and Health Services

**Alan E. Greenberg, MD, MPH**  
Professor and Chair  
Department of Epidemiology and Biostatistics  
George Washington University School of Public Health and Health Services  
Chair, ACD, CDC

**Kelly J. Henning, MD**  
Director, Public Health Programs  
Bloomberg Philanthropies



**George Isham, MD, MS** (via telephone)  
Chief Health Officer  
HealthPartners, Incorporated

**Herminia Palacio, MD, MPH**  
Executive Director  
Harris County Public Health and Environmental Services

**Lynne D. Richardson, MD, FACEP**  
Professor and Vice Chair of Emergency Medicine  
Professor of Health Evidence and Policy  
Mount Sinai School of Medicine  
Chair, HDS

**ACD Members Absent:**

**Anthony B. Iton, MD, JD, MPH**  
Senior Vice President, Healthy Communities  
The California Endowment

**Sylvia Drew Ivie, JD**  
Executive Liaison, Commission for Children and Families  
LA County

**Sara Rosenbaum, JD**  
Harold and Jane Hirsh Professor and Founding Chair of the Department of Health  
Policy  
George Washington University

**CDC Staff Attending:**

**Kate Agin**  
OSTLTS

**Jon Altizer**  
Contractor, Deloitte  
OADP

**Ileana Arias, PhD**  
Principal Deputy Director, CDC

Drue Barrett, PhD, CAPT, USPHS  
Public Health Ethics Coordinator  
Office of the Chief Science Officer  
Designated Federal Officer, Ethics Subcommittee, ACD



**Beth Bell, MD, MPH**

Director  
National Center for Emerging and Zoonotic Infectious Diseases

**Sherri Berger, MSPH**

Chief Operating Officer  
Office of the Director, CDC

**Mark Byers**

Advance Team  
Office of the Chief of Staff  
Office of the Director

**Colleen A. Boyle, PhD, MS Hyg**

Director  
National Center for Birth Defects and Developmental Disabilities

**Denise M. Cardo, MD**

Acting CDC Deputy Director for Surveillance, Epidemiology, and Laboratory Services

**Laura Conn, MPH**

Public Health Surveillance and Informatics Program Office, OSELS

**Katherine Lyon Daniel, PhD**

Associate Director for Communication  
Office of the Director, CDC

**Justin Davis, MPH**

Orise Fellow  
Office of Prevention Through Healthcare, OADP

**Hazel Dean, ScD**

Deputy Director  
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

**Linda Degutis, DrPH, MSN**

Director  
National Center for Injury Prevention and Control

**Pam Diaz, MD**

Director, Biosurveillance Coordination Activity, PHSIPO, OSELS

**Heather Duncan, BS, MH**

Deputy Chief of Staff  
Office of the Director, OD



**Hilary Eiring**

Office of Prevention Through Healthcare, OADP

**Thomas R. Frieden, MD, MPH**

Director, CDC

**Neelam Ghiya, MPH**

Special Assistant to the CDC Director

Advance Team

Office of the Chief of Staff

Tanya Hart

Evaluation Fellow

Office of the Associate Director for Program

**Gayle J. Hickman**

Committee Specialist, ACD

Advance Team

Office of the Chief of Staff

Office of the Director

**John Howard, MD, MOH, JD, LLM**

Director

National Institute for Occupational Safety and Health

**Harold Jaffe, MD, MA**

Associate Director for Science

**Dan Jernigan, MD, MPH**

Deputy Director, Influenza Division, NCIRD

**Natalie Jones**

Deloitte Contractor, OADP

**Rima Khabbaz, MD**

CDC Deputy Director for Infectious Diseases

**Ali Khan, MD, MPH**

Director

Office of Public Health Preparedness and Response

**Leandris Liburd, PhD, MPH, MA**

Director

Office of Minority Health and Health Equity

Designated Federal Officer, HDS



**Judy Lipshutz, MPH**

Public Health Analyst  
Office for State, Local, Tribal and Territorial Support

**Judith A. Monroe, MD, FAAFP**

CDC Deputy Director, Office for State, Tribal, Local, and Territorial Support  
Designated Federal Officer, State, Tribal, Local, and Territorial Work Group

**Ann E. O'Connor, MPA**

Acting Associate Director for Program

**Andrew S. Rein, MS**

Associate Director for Policy

**Laura Seeff, MD**

Acting Director, Office of Prevention Through Healthcare, OADP

**Pattie M. Simone, MD**

Principal Deputy Director  
Center for Global Health

**Tom Skinner**

Public Affairs Specialist, News Media Branch  
Division of Public Affairs, OADC

**Carmen Villar, MSW**

Chief of Staff  
Designated Federal Officer, Advisory Committee to the Director

**Keith Willing**

Office of Surveillance, Epidemiology, and Laboratory Services

**General Public:**

**Ruth Gaare Bernheim, JD, MPH** (via telephone)

Chair, Department of Public Health Sciences, School of Medicine  
Associate Director, Institute for Practical Ethics and Public Life  
University of Virginia  
Chair, Ethics Subcommittee, ACD

**Kendra Cox, MA**

Writer/Editor, Senior Technical Writing Lead  
Cambridge Communications



Advisory Committee to the Director: Record of the April 25, 2013 Meeting

**Dee Dee Honaman**

Vice President for Advancement  
CDC Foundation

**Verla Neslund, JD**

Vice President for Programs  
CDC Foundation

**Charles Stokes**

President and CEO  
CDC Foundation



**Attachment #2: Acronyms Used in this Document**

<b>Acronym</b>	<b>Expansion</b>
ACA	(Patient Protection and) Affordable Care Act
ACD	Advisory Committee to the Director
ACIP	Advisory Committee for Immunization Practices
ACO	Accountable Care Organization
APHA	American Public Health Association
ASLM	African Society for Laboratory Medicine
ASTHO	Association of State and Territorial Health Officials
ATO	Authority to Operate
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CGH	Center for Global Health
CHNA	Community Health Needs Assessment
CME	Continuing Medical Education
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CR	Continuing Resolution
CRE	Carbapenem-resistant Enterobacteriaceae
CSPHS	Center for Sharing Public Health Services
CTG	Community Transformation Grant
DFO	Designated Federal Officer
EAPO	Epidemiology and Analysis Program Office
EHR	Electronic Health Record
EIS	Epidemic Intelligence Service
EPA	Environmental Protection Agency
EVA	Employee Viewpoint Survey
FACA	Federal Advisory Committee Act
FETP	Field Epidemiology Training Program
FOA	Funding Opportunity Announcement
FY	Fiscal Year
GWG	Global Work Group
HAI	Healthcare-Associated Infection
HDS	Health Disparities Subcommittee
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	(United States Department of) Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IRS	Internal Revenue Service
IT	Information Technology



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<b>Acronym</b>	<b>Expansion</b>
MASO	Management Analysis and Services Office
MCH	Maternal and Child Health
MMWR	Morbidity and Mortality Weekly Report
NACCHO	National Association of County and City Health Officials
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCD	Noncommunicable Disease
NCHS	National Center for Health Statistics
NGO	Non-Governmental Organization
NHANES	National Health and Nutrition Examination Survey
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NNDSS	National Notifiable Diseases Surveillance System
NPS	National Prevention Strategy
NQS	National Quality Strategy
OD	Office of the Director
OI	Organizational Improvement
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSTLTS	Office of State, Territorial and Tribal Support
PCPHI	Primary Care Public Health Initiative
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
QI	Quality Improvement
REACH	Racial and Ethnic Approaches to Community Health
ROI	Return On Investment
RWJ	Robert Wood Johnson (Foundation)
SELS	Surveillance, Epidemiology, and Laboratory Services
SGE	Special Government Employee
SIM	State Innovation Model
STD	Sexually-Transmitted Disease
STLT	State, Local, Tribal, and Territorial
TA	Technical Assistance
TB	Tuberculosis

