Meeting Purpose
Review and provide feedback on emerging issues facing CDC and impacting STLT public health agencies; review and make recommendations as appropriate on public health financing, surveillance and the social/structural determinants of health; review accomplishments of STLT Subcommittee efforts to date as basis for considerations for the future; and discuss and set the agenda for the STLT Subcommittee moving forward.

STLT Subcommittee Attendees
Wilma Wooten (Chairperson), Jay Butler (on-site facilitator), Nicole Alexander-Scott, Terry Allan, Emi Chutaro, Georgia Heise, Julie Morita, LaQuandra Nesbitt, Umair Shah, John Wiesman, and Jose Montero (Designated Federal Official).

Other Attendees
Judy Lipshutz, Sarah Bacon, James Mercy, Melissa Merrick, David Ross, David Baden, Duane Stone, Bill Gallo, Andrea Young, Liza Corso, Marilyn Metzler, Karina Lifschitz, Marrielle Mayshack, Georgia McIntyre, Pam Meyer, Steve Reynolds, Chelsea Payne, Georgia Moore, Dagny Olivares, Craig Thomas, Cambra Lee Shapiro, and Melanie Duckworth.

Notes: Coretta Monroe, Gia Simon

Welcome/Call to Order
Jay Butler and Wilma Wooten jointly called the meeting to order.

Introductions
All members introduced themselves. There were no conflicts of interest.

CDC Update
- Dr. José Montero provided an overview of priorities, current challenges, and updates for CDC and OSTLTS. One focus of Health and Human Services Secretary, Dr. Tom Price, is addressing the opioids epidemic. CDC Director, Dr. Brenda Fitzgerald, is interested in improving implementation of CDC strategy in the field - regardless of the size of the health department or agencies. CDC needs to develop better management of the surveillance component. A particular area of interest for Director Fitzgerald is early childhood brain development
- Dr. Montero described OSTLTS’s role and the kinds of information OSTLTS needed from the field to better support them. For example, what types of CDC technical assistance would be most helpful to STLTs or what types of capacity building was needed for STLTs to be more effective?
OSTLTS is a service organization and (1) serves both CDC programs and STLT health officials/agencies; (2) helps CDC programs understand and factor into their work the characteristics, needs, challenges, and priorities of STLT health agencies and the populations they serve; (3) helps STLT health officials connect directly with CDC expertise, programs, services and other support to address STLT-specific or system-wide issues; and (4) encourages collaborative system-wide thinking and solutions and out-of-the-box thinking.

CDC technical assistance to STLTs is delivered as a program, action, or activity. OSTLTS assists STLTs in building infrastructure and offers support for determining individual STLT priorities and aligning them for maximum effectiveness.

The STLT Subcommittee could help STLTs become more effective through the recommendations the committee submits for adoption through the Advisory Committee to the CDC Director.

- OSTLTS is supporting many STLTs with their reaccreditation efforts. CDC has shifted its perspective of accreditation as not just a goal/endpoint but also a tool for improvement.
- OSTLTS Director’s current priorities include improving population health outcomes through improved technical assistance to public health agencies, exploring implementation and public health systems science, and improving internal CDC coordination by addressing social determinants of health, rural health, and health systems integration.
- Dr. Andrea Young explained a framework developed to measure the effectiveness of the Preventive Health and Health Services Block Grant. OSTLTS is taking multi-component approach to the framework, with systems measurement being one of the components. A preliminary report on key findings was expected Spring 2018.

Dr. Montero asked the committee members to consider the following key questions as they decide which recommendations to send forward to the Advisory Committee to the Director:

**Social Determinants of Health**
- Is CDC able to incorporate a SDOH framework across all programs that states can easily implement?
- How can CDC intentionally translate a SDOH framework into actions and activities for each program and policy?
- Can current tools like the Foundational Practices for Health Equity Tool (CoIIN model/scorecard for health equity) be adapted as a roadmap for engagement?

**General**
- What are some best practices for ensuring that technical assistance is available at all levels of the public health enterprise (federal, state, tribal, local, and territorial)?
- Is OSTLTS providing the right support for STLTs?
- What can OSTLTS improve?
- What is OSTLTS not doing that the office should start?
- What should OSTLTS stop?
- If STLTs ask for more, what are they willing to give up?
Group Discussion on CDC Update

- It would be helpful to STLTs to know what types of technical assistance CDC can provide to them
  - When STLTs request support, CDC should figure out how to better organize their efforts to provide the specific support for STLTs.
  - STLTs were encouraged to talk to CDC as they begin thinking about priorities which would help CDC consider what types of structures might work best for STLTs.
- **Recommendation:** Add another measure for the PHHS Block Grant evaluation project to assess the systematic improvement effect of health outcomes in a positive way.
  - Andrea Young elaborated that a multi-component approach was being used. Initial results are promising related to funding and outcomes (how grantees were allocating their funds and what was being achieved with Healthy People 2020 objectives).

Welcome from New CDC Director

- Dr. Brenda Fitzgerald, Director of CDC/ASTDR, welcomed committee members and invited them to ask questions.

Comments/Questions between members and Dr. Fitzgerald

- NACCHO President, Umair Shah, encouraged Dr. Fitzgerald and CDC to reach out to their organization as they continue to work on important policy issues. NACCHO is also interested in bolstering their global interactions.
- CDC is positioned to help align and strengthen local and state public health agencies. Together with CDC, state and local health departments form a triad. All three entities must work together to strengthen public health.
- The Public Health Associate Program (PHAP) is very valuable to the STLTs.
- Dr. Fitzgerald encouraged committee members to give feedback on ways to improve public health surveillance. Integration of all of the surveillance systems was one of the top five priorities.
- Emi Chutaro (Executive Director, Pacific Island Health Officer Association) appreciated that there was integration across CDC programs, especially for small health systems (e.g., Zika virus, categorical program response), but that integration can pose certain challenges. The Pacific Island’s health systems are integrated, but when CDC categorical programs come in to help, they create some disintegration. Approaches that historically work on the US mainland sometimes do not work on the smaller islands, something CDC needs to understand.
- Dr. Fitzgerald agreed that CDC needs to go beyond supporting programs with funding, but also to ensure that the programs are effective.
- CDC could bring all of the Project Officers (POs) together to help them understand that HDs work on all of the programs (categorical, etc.) at one time. It would be helpful for POs to work together and use the money smartly at the local level versus Congress telling CDC to use the money for just this purpose/categorical issue.
- Observation of Dr. Fitzgerald – Isolation of CDC’s Centers, Institutions, and Offices (CIOs) affects funding disbursement and ability to coordinate funding streams. Getting to a quick
answer when there is an emergency is also a challenge. For example, initially during the Zika Virus response, the birth defects center and the Zoonotics office were not working together. However, progress has been made to further integrate CDC CIO responses and coordinated strides to better understand the perspectives of insular islands and small/rural HDs.

- Committee members appreciated that Dr. Fitzgerald had the vision to build on the progress the STLT Subcommittee and think tanks had made. The structural determinants of health in the communities could be addressed with better CDC CIO integration and could have a positive effect on the affected communities. The committee was eager to help in any way as Dr. Fitzgerald and CDC engaged HRSA and CMS.
- Dr. Fitzgerald appreciated the committee members’ well wishes and looked forward to hearing more of their feedback.

Public Health Finance Think Tank

**CDC Budget: Update**

*Dave Baden, Deputy Chief Financial Officer, Office of Financial Resources, CDC*

- Dave Baden gave an overview of CDC’s budget and how Congress expected the agency to spend its dollars.
- CDC program level funding is the discretionary budget that Congress appropriates to CDC every year. The Preventative Health & Health Services (PHHF) funds were expedited this fiscal year to Block Grant recipients. That concerted effort showed that getting funds out sooner was possible.
- There is an overall 18% reduction for CDC funding in the President’s budget. Included in the President’s budget is a new chronic disease Block Grant proposed at $500 Million, a new initiative for Tribes remained ($16 M) and public health preparedness funding remained. There is also an increase in funding for the Injury Center to address the opioid crisis. However, the current and proposed PHHF Block Grant funding line was not supported. There is a reduction in FY 17 dollars and the REACH program was eliminated.
- For the insular islands and territories, their distinctive statuses define the programs for which they are eligible. CDC has to define those statutes and make allowances for them. Three sovereign nations were not eligible for WIC and other CMS programs. Although the standards for applying for block grants were the same for everyone that applied, an unintentional disparity exists between jurisdictions. When the funding trickles down to where the funds are applied, those standards did not make sense for smaller and insulated areas.
  - **SUGGESTION:** The Finance Think Tank should dedicate some time to understand the funding formula and how the insular islands get their money.
- Congress asks CDC to report on 133 separate funding lines. The funding spreadsheet can be accessed at [www.cdc.gov/budget](http://www.cdc.gov/budget). For the current administration’s budget, CDC proposed rolling up the funding line sublines for easier reading and to demonstrate flexibility. Most of the additional lines came on the spreadsheet from advocacy groups. CDC has attempted to combine the lines for budget activities, but Congress will sometimes ask that the lines be teased
out for easier reading. There is an opportunity to change how CDC structures the budget spreadsheet.

- CDC does submit a policy justification with the budget on how the proposed cuts would affect the nation’s health.
  - SUGGESTION: CDC should proactively consider how dollars actually get to jurisdictions. That could be a program or finance level decision. The changing demographics and where the dollars would have the most impact should be a consideration
    - Note that grant eligibility is established from a legal standpoint and is based on HHS grant policy. “Flat and full open competition” is an HHS policy requirement. There is an opportunity to guide funding considerations as the subcommittee and CDC further look into the funding process.

Public Health Finance Think Tank Report/Actions
John Wiesman, Public Health Finance Think Tank Chairperson

- The STLT Subcommittee asked the Finance Think Tank to Explore funding strategies that leverage new and existing funding opportunities to support core public health infrastructure needed in STLT agencies to protect and promote health across the nation
  - The think tank should consider the likelihood of reduced federal funding from CDC, coupled with potentially greater flexibility in how resources are distributed and used.
  - Considerations: Ties to foundational services, weaknesses and gaps in system, way to move forward while recognizing that not all populations are equal (rural, minorities, etc.).

- The three potential recommendations included:
  - CDC should develop national criteria, guidance, and best practices for state/local funding decision making and distribution of funds.
  - CDC should require joint STLT resource and allocation planning for notice of funding opportunities (NOFOs).
  - CDC should establish a mechanism that addresses and ensures resource and service delivery reach the appropriate geographic level for better health outcomes.

- These recommendations had opportunities and risks for consideration:
  - Opportunities:
    - Improved alignment among STLTs could increase the chances of “moving the needle” on health outcomes. This could be particularly true when some local health authorities (LHAs) carry significantly more disease burden in a state compared to their population size or to other LHAs in the same state.
    - Joint resource and allocation planning would allow STLTs an opportunity to mutually evaluate data regarding the health status and disparities of its populations, identify priority health issues for action, identify priority interventions for funding, and measures to evaluate change.
    - Support the development of a common funding platform or model based on national accreditation standards to strengthen capabilities, improve performance and accountability.
Consideration of blended and/or braided funding strategies coupled with accountability could leverage other funding sources, yielding greater efficiency and impact.
  - Could serve as a catalyst for multi-sector cooperation that could broaden the range of services provided across a larger geographic area and be more proportionate to the need.

**Risks**
- As money is shifted from one entity to another, there are perceived “winners” and “losers” increasing tensions and defunding projects that communities/agencies have been relying upon to address priority health problems.
- The ways in which CDC and states fund local health agencies could create greater tension among state/territorial and Tribal/local health departments, resulting in a fragmented and under-resourced public health system.
- Complex funding decision-making strategies could result in greater supplantation of funds, which in the long run will not benefit the system.
- For state health departments, shifting more dollars to locals, especially in an environment with decreased funding overall, may undercut the infrastructure locals count on from states (e.g., laboratory capacity, surge capacity, technical assistance, specialized expertise only housed at a state/large jurisdiction level).

**Group Discussion on Finance Recommendations**
- The think tank is not ready to make formal recommendations. These are fairly draft; the think tank needs time to explore the feasibility of working with OFR to find the best approach.
- In the third recommendation, it should be clear that CDC is proactively, continually looking at a quality improvement process and looking at gaps.
- There needs to be consistency of language between first and second recommendations.
- Clearly define what is meant by “resources and service delivery” in the third recommendation.
- Include tribes and territories in all of the recommendations; change “state/local” to “state, tribal, local, and territorial.”
- The language needs to be clear that this means working with a larger block grant approach, but be mindful about how it is written related to small jurisdictions.
- The think tank should not lose a sense of urgency in moving forward.

**Action**
- The think tank will bring the feedback to its next meeting to refine the three recommendations.
- The think tank will consider eligibility requirements are and how they are different for different jurisdictions.
Social Determinants of Health Think Tank

- Before hearing the think tank’s recommendations, the committee listened to two presentations about emerging focal areas: adverse childhood experiences and opioids.

**Adverse Childhood Experiences (ACEs)**  
*James Mercy, Division Director, and Melissa Merrick, Behavioral Scientist Division of Violence Prevention, National Center for Injury Prevention, CDC*

Selected highlights of presentation
- Adverse Childhood Experiences (ACEs) included more than just child maltreatment. Early adversity has a lasting impact on health.
- Building brain architecture has proven to be essential. Certain experiences can affect the way the brain develops, though none is deterministic. Experiences have a cumulative effect on a child’s brain.
- CDC’s National Center for Injury Prevention released technical packages for prevention.
- CDC’s **Essentials for Childhood Framework** intervention:
  - Raise awareness and commitment to support safe, stable, nurturing relationships and environments;
  - Use data to inform action;
  - Create the context for healthy children and families through norms change and programs; and
  - Create the context for healthy children and families through policies.
- CDC is funding 5 state health departments - Essentials for Childhood Framework initiative:
  - California, Colorado, Massachusetts, North Carolina, and Washington; and
  - 39 self-supported states plus DC are participating in initiative in some way, with training and technical assistance available through CDC.
- Preventing early adversity requires understanding why some children and families are at greater risk than others for ACEs.
- Trauma informed systems are needed.

**Opioids**  
*Sarah Bacon, Team Lead, State Opioid Overdose Prevention State Support Team, Division of Unintentional Injury Prevention, National Center for Injury Prevention, CDC*

Selected highlights of presentation
- The opioid epidemic is getting worse.
- This epidemic is unique in that geography is driving vulnerabilities. Place matters and can be part of structural determinants of health.
- Three pillars of CDC activities:
  1) Enhanced State Opioid Surveillance
     a. Strategy One: increase timeliness of non-fatal opioid overdose reporting.
     b. Strategy Two: increase timeliness of fatal opioid overdose reporting.

2) Prevention for States Program
   a. Enhance and maximize prescription drug monitoring programs.
   b. Community or health system interventions: Implement or improve opioid prescribing interventions for insurers, health systems, or pharmacy benefit managers.
   c. Rapid response project: Allow states to move on quick, flexible projects to respond to changing circumstances on the ground and move fast to capitalize on new prevention opportunities.
   d. State policy evaluation: Build evidence base for policy prevention strategies that work like pain clinic laws and regulations, or naloxone access laws.

3) Data Driven Prevention Initiative – Awarding $18 million over a 3-year period to 13 states and District of Columbia to:
   a. Improve data collection and analysis around opioid misuse, abuse, and overdose;
   b. Develop strategies that impact behaviors driving prescription opioid dependence and abuse;
   c. Work with communities to develop more comprehensive opioid overdose prevention programs; and
   d. To develop more comprehensive opioid overdose prevention programs.

- The state initiative has five components and is where the program work begins: Prescription Drug Monitoring Programs (PDMPs), System-Level, Evaluate Policy, Surveillance, and Rapid Response.
- Many states are needed to build the foundation and establish the relationships for data collection.
- CDC released opioid prescribing guideline in March 2016’s MMWR.
- The geographic structural determinant sets the stage for addressing the vast disparities among counties. If place is used as a focus, a specific strategy could emerge.

Discussion on Emerging Focus Areas
- Committee members appreciated the timeliness of sharing data and the partnership between public health and law enforcement.
- OSTLTS can help disseminate information about national trends and efforts around addressing new developments as they unfold. Rapid detection around medical examiner data is critical.
- It is essential to collaborate with law enforcement for meaningful data sharing, even if the data are not entirely accurate.
- The data are moving slower than the situation, which creates an opportunity for systemic changes. Consider what role the federal agencies have in helping states track these data.
- Health officials need recommendations about what to do with the data. What are the practical uses? How does CDC work with other communities that have the data? How can they share information? How and what do they use it for?
• CDC can provide technical assistance. One of the most robust ways CDC can support partners is through peer-to-peer learning that will help answer “so what?” about dated collected.
• The data can be used to inform prevention actions. There is evidence that population-level strategies reduce the burden on families. Preventing ACEs will prevent other chronic diseases and early adversity.
• CDC should be careful when assuming that data or systems are available to all jurisdictions. Some jurisdictions face developmental steps along the way first.
• It is difficult to use funds to blend issues that address determinants of health when required to report individual line items.
• The Essentials for Childhood Framework can be a model to address determinants of health.
• The opioid crisis has created an opportunity and underscored the necessity of establishing a national electronic record for timely data sharing.
• Health officials needed recommendations about what to do with the data. What were the practical uses for having data in real time? How could CDC work with the community’s data to help STLTs create an alert/fact sheet and apply it to different audiences?
• ACE data can be used to identify prevention actions. Those data might be taken to policy and stakeholders to make the program work better. Preventing ACEs would prevent chronic diseases and early adversity. The March 2016 Technical Package and the cross-cutting package under development would help to address the social and structural determinants of health. When public health invests early in conditions that support families, it makes a difference.
• There was a need to integrate trauma care into public health practice.

Report, SDOH Think Tank
Julie Morita, Social (Structural) Determinants of Health Think Tank Chairperson

• This work has two phases:
  o Phase 1 (before 2017) – What work has been done since 2014 when the work group was formed.
    ▪ The purpose has been redefined
    ▪ To date, the ACD has adopted six recommendations developed by the SDOH Think Tank
    ▪ There is a long-term goal for CDC social norm change that incorporates SDOH as a part of the fabric of the way CDC does all its work.
  o Phase 2 (going forward) – Redefine the direction of think tank and rename it to replace “social” with “structural” because the work goes beyond “social determinants of health.”
    ▪ Structural includes economic and environmental factors. There is a need to expose and address the systematic structural factors that lead to the differential health outcomes: Social justice concerns, including racism.
• Use this structural approach to build on known reports and their recommendations related to social determinants of health.
Communities in Action: Pathways to Health Equity (NASEM)* Recommendation 7-5: The committee recommends that public health agencies and other health sector organizations build internal capacity to effectively engage community development partners and to coordinate activities that address the social and economic determinants of health. They should also play a convening or supporting role with local community coalitions to advance health equity.

Public Health 3.0 (HHS): Public health leaders should embrace the role of chief health strategist for their communities—working with all relevant partners so that they can drive initiatives, including those that explicitly address “upstream” social determinants of health. Specialized public health 3.0 training should be available for people in or preparing to enter the public health workforce.

Recommendation
- CDC should develop a clearly understood vision for social determinants of health in public health and create social determinants of health plan to achieve that vision.
  - The think tank acknowledges CDC’s role as chief health strategist and the need for cross-CDC program and cross-federal agency collaboration.
    - Funding and policy strategies
  - Includes language, information, and program activities to be used by STLT public health agencies to engage non-traditional partners.
    - Attributable risk of social determinants of health on public health priorities
  - Includes a framework for place-based interventions and community empowerment to be used by STLT public health agencies to address social determinants of health.
    - Require addressing structural factors, including racism

Discussion
- Did the think tank consider using only “determinants of health?” The World Health Organization defines “determinants of health” to include everything the committee was discussing.
- By using only “determinants of health,” the think tank would lose the social/structural piece and focus only on the biological factors. The social/structural piece should remain because that was where development was needed.
- CDC needed to be intentional about exposing the structural challenges and the role structure played in addressing health equity.
- There could be another “S” for “stress,” which was also a huge driver of health equity.

SDOH Action Items
- The recommendations were supported but will be refined before the next STLT Subcommittee meeting.
- The committee would continue to consider the intent and definitions of the terms used because they had an effect on CDC’s abilities.
Ethics Requirements Reminder

*Duane Stone, Management & Program Analyst, Management Analysis and Services Office, CDC*

- As per Federal Advisory Committee Act, the committee members were reminded about ethics requirements and provided written information with details.

Public Health Surveillance Think Tank

*Digital Bridge: What it Means for Health Departments*

*David Ross, President and CEO, Taskforce for Global Health and Member, Public Health Surveillance Think Tank*

- The [Digital Bridge](#) initiative was a public-private partnership coordinated by Robert Wood Johnson Foundation that aims to improve the health of our nation by enhancing information exchange between health care and public health.
- The Digital Bridge is a partnership of health care, health IT, and public health organizations to ensure a bi-directional flow between health care and public health.
- The initial focus was establishing electronic case reporting (eCR), which is the automated generation and transmission of case reports from the electronic health record (EHR) to public health agencies for review and action.
- The challenge was getting all entities on the same system. The system that public health used does not talk directly to the health care’s IT system.
- The initial demonstration effort focused on an interoperable, multi-jurisdictional approach to electronic case reporting (eCR), which builds on a 3-year exploratory project, the Public Health Community Platform, led by ASTHO.
- The first phase of work had begun with the pilots and reportable disease. The first set of reportable diseases included Gonorrhea, Chlamydia, Salmonella, Pertussis, and Zika Virus.
- Electronic Case Reporting Site Participants included:
  - Wave 1 (April – Fall 2017): Kansas, Michigan, Utah; and
  - Wave 2 (Fall 2017 – Early 2018): California, Houston, Massachusetts, New York City.
- Public health needed to work with clinical care and behave as one, using one set of standards, to get data.
- The questions will be (1) are the right data elements being captured and, (2) as the information moves over, can it be analyzed.
- A possible governance question regarding tribal nations would be who owns tribal data. The Digital Bridge governance was in place to work out jurisdictional questions.
- [San Diego Connects](#) was one example where multiple entities report into one system. Wilma Wooten shared that their system was a federated model in which all agreed to share data and is a local health exchange information system.
- Progress was happening in a variety of locations. The challenge was getting the data standards uniformed over time.
- The Pacific Islands reported into one surveillance system and it encompassed all hospitals and healthcare clinics. The territories and islands in the region agreed to have one standard. However, they needed help getting on an equal playing field as the mainland US because their data forms are Excel-based using manual labor. The various levels of readiness for insular islands and rural/local HDs need to be considered.
Other considerations included:

- Physical location of STLTs;
- The Veterans Administration system was a closed system;
- Intergenerational providers’ ability to use electronic systems;
- Engaging hospital associations, to help influence provider buy-in and early adoption;
- Non-reportable conditions need the right data agreements to confidentially identify people, and follow them over time; and
- Best way to get chronic disease and SDOH data.
- Legal Questions: what could be done? How will the data be used?
  - The more difficult questions have been parked until Phase Two begins.

**Public Health Surveillance Think Tank Report/Actions**

*Terry Allan, Public Health Surveillance Think Tank Chairperson*

To ensure STLT public health agencies are able to participate in bidirectional information exchange with healthcare, CDC should work with partners in STLT public health, healthcare, and developers of health information technology to develop an analysis of the costs of building and maintaining the national health information infrastructure. Based upon that analysis, CDC should work with these partners to prepare a comprehensive strategy for developing, governing, funding, and maintaining local, state and federal participation in the system for the coming decade.

- This recommendation builds on progress made to date: Supported by ACD-adopted recommendations and based on the CDC Surveillance Strategy, CDC has made impressive progress during the past three years on a comprehensive surveillance system modernization initiative aimed at reducing inefficiencies and redundancies.
- There is a need to come to an agreement about the standards so all can use them and to have them uniform over time.
- The concept of “one public health” needs to be defined better. For some jurisdictions, there is a digital divide, so not all jurisdictions can have the same requirements.
- There is a need to consider where investments can be allocated best and targeted where people are in their system—how can all boats be raised? What is the basic minimum before there is “one system?”
- When a public health agency, regardless of size, needs to gain access to work with clinical care, they have to behave as one to get the data.
- Start with standards as the way to get the conversation started between health care, health IT, and public health so all understand what is needed and can be gathered through what is currently available.
- Governance is another element to consider—when it comes to tribes, who owns tribal data?
- The fact that electronic health records are in all hospitals (in 48 states) is an enabling factor to start the conversation.
- A driving factor could be to add a requirement that physicians are required to report to health departments.
- The system must have three characteristics:
This is about a minimum standard. The reality is that every place is different and not all have the same structure or resources.

Electronic health records disrupt physicians’ work flow, so the system must be something that doesn’t burden doctors.

The system can’t be something that would put health departments, hospitals, doctors, etc. to incur extra cost to pay for the vendors.

- Digital Bridge and all public health organizations have taken these characteristics and are now in an implementation phase and within a year agreeing on standard measures.

**Discussion**

- There needs to be consideration for jurisdictions that do not have the technological infrastructure (e.g., Insular Areas and rural areas).
- Equities across systems must be examined, regardless of where the STLTs are physically located.
- It is critical to keep going past the infectious diseases reporting. The challenges for public health are the chronic conditions.
- Reporting chronic diseases will introduce certain legal questions, such as what can be done? How will these data be used?
- Non-reportable conditions need the right data agreements to confidentially identify people and follow them over time.
- After the pilot, there is a plan to broaden the number of sites, as well as to provide technical assistance and increase the number of reportable conditions.
- Tribal and territorial language needs to be added to the last sentence of the recommendation.

**Action**

- There were no objections to moving forward with the recommendation for consideration.

**Public Comment**

There were no public comments

**Summary and Future Priorities**

- This is a good time to synthesize the information for the director and provide information about what has been developed.
- Integration was a theme throughout the meeting. Data systems need to be able to fulfill integration needs, but public health cannot wait until all of the systems are in place and must work toward that while activating areas that must be addressed now.
- There was an emphasis on structural and social determinants of health. The integration themes can encourage CDC to think about how to support STLTs differently and how to be intentional about that.
- CDC leaders should consider CDC use of a program area that is a priority of the director (e.g., opioids) and demonstrate how the think tanks’ recommendations relate to that priority. This is an opportunity to express one of the public health priorities in a practical way.
• The committees would like to meet more frequently, more than once per year. This will enable them to resolve things more quickly.
• A key area to continue to focus on is clinical IT and early innovation. Public health needed to look beyond traditional partners for engagement and identify innovation opportunities. For example, Harris County, Texas worked with Microsoft to work on mosquito abatement.
• CDC has a role as a catalyst at the federal level and as the convener bringing others to the table, especially when looking at structural and social determinants of health. How do we really intersect with them?
• The dialogue between CDC’s program staff and STLTs is very valuable, all learn from each other. There is hope that there will be more of it in the future.
• CDC leading the way as far as federal agencies interested in STLTs. Committee members should continue to educate each other within the group to work together more cohesively.
• The committees have thought of the same messages, which will help STLTs work on same things that are causing problems for all of them.
• The committees should consider how STLTs can provide CDC with information and look at themselves in terms of the public health enterprise.
• Director Fitzgerald’s enthusiasm for the current subcommittee projects and the progress made was very encouraging.
• The STLT Subcommittee members should consider adding a TAC liaison as a member.
• Structural and social determinants of health are common threads. What role do they play, and how can STLTs connect, share lessons, and improve implementation for all of those different things? There should be more in-depth conversations, which will modify and improve the committee’s work.
• Subcommittee members appreciated CDC asking for feedback and listening to the recommendations to better inform the agency. Members were thanked for their commitment to moving the work forward.
• Both the subcommittee meeting and the previous day’s think tank meetings were very informative and productive. There were high expectations for continued progress, especially from the Surveillance Think Tank.

Adjourned
The meeting adjourned at 2:39 PM

Next STLT Subcommittee Meeting: To Be Announced
Certification

I hereby certify that, to the best of my knowledge and ability, the forgoing minutes of August 11, 2017 meeting of the State, Tribal, Local and Territorial Subcommittee are accurate and complete.

October 19, 2017
Date

Wilma Wooten, MD, MPH