State, Tribal, Local and Territorial (STLT) Subcommittee
Advisory Committee to the Director of CDC
Meeting Minutes

August 2, 2018 | 8:30 am–3:30 pm

Meeting Purpose
- Review and provide feedback on emerging issues facing CDC and affecting state, tribal, local, and territorial (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
- LaQuandra Nesbitt, MD, MPH (Chairperson), Director, District of Columbia Department of Health
- Nicole Alexander-Scott, MD, MPH, Director, Rhode Island Department of Health
- Terry Allan, MPH, Health Commissioner, Cuyahoga County Board of Health
- Nicolas Barton, MBA, Executive Director, Department of Health, Cheyenne and Arapaho Tribes
- Jay Butler, MD, Chief Medical Officer and Director of Public Health, State of Alaska
- Emi Chutaro, MSc, Executive Director, Pacific Island Health Officer Association
- Mary Currier, MD, MPH, State Health Officer, Mississippi State Department of Health
- Hector Gonzalez, MD, MPH, Director, City of Laredo Health Department
- Georgina Heise, DrPH, Director, Three Rivers District Health Department
- Julie Morita, MD, Commissioner, Chicago Department of Public Health
- Umair Shah, MD, MPH, Executive Director, Harris County Public Health
- Mylynn Tufte, MBA, MSIM, BSN, State Health Officer, North Dakota Department of Health
- John Wiesman, DrPH, Secretary of Health, Washington State Department of Health
- José Montero MD, MHCDS (designated federal officer), Director, CSTLTS, CDC

CDC Representatives

Notes: Gia Simon

Other Attendees
Lori Freeman (NACCHO), Marcus Plescia (ASTHO), David Ross (Taskforce for Global Health), Jeanne Ayers (Minnesota Department of Public Health), Ed Baker, Perry Smith (School of Public Health, Albany, NY)
Welcome/Introductions

LaQuandra Nesbitt, MD, MPH, STLT Subcommittee Chairperson

- Dr. LaQuandra Nesbitt called the meeting to order and asked the subcommittee members to consider the following throughout the day:
  - Are the current think tanks the right ones or should there be another think tank for emerging issues? Should the subcommittee create a new think tank, consolidate think tanks, or assign emerging issues within the current think tanks?
  - How does the STLT Subcommittee function? The subcommittee is not only charged with making recommendations to the Advisory Committee to the Director to move to Dr. Robert Redfield, the subcommittee is also responsible for having conversations with the Center for State, Tribal, Local, and Territorial Support (CSTLTS) (proposed), and thinking about how to officially work with health officials who operate on the ground.
  - Think proactively and strategically to keep work moving forward in a bidirectional way.
  - Do not just make recommendations to the Advisory Committee to the Director, but make them in ways that can help make the work more meaningful.
- Dr. Nesbitt introduced the three new STLT Subcommittee members—Nicolas Barton, Mylynn Tufte, and Hector Gonzalez.
- All members introduced themselves. There were no conflicts of interest.

Report from CSTLTS

José Montero, MD, MHCDS, Director, Center for State, Tribal, Local, and Territorial Support (proposed)

- José Montero provided an overview of the proposed CDC reorganization and described CSTLTS’s role within the new structure.
- CSTLTS aggregates the information that health officials produce; CSTLTS does not generate the data but does give it back to the field in different ways.
- CSTLTS innovates and has a great capacity to serve as a reference center for the country, and in many cases, the world.
- José Montero explained CDC’s proposed organization into communities of practice—putting existing offices and centers at CDC together that have things in common so they can learn from each other. These include:
  - Infectious Diseases
  - Non-Infectious Diseases
  - Public Health Science and Surveillance, which already includes the Center for Science, Epidemiology and Laboratory Services and the National Center for Health Statistics, and will add the Office of Science (proposed) and the Office of the Associate Director for Laboratory Science and Safety
  - Public Health Service and Implementation Science—CSTLTS will be in this new community of practice, and will identify things in common with the other office and centers in this group. Within this context, different centers will seek ways to better provide services to the country and the world.
- The hope is that the change from “office” to “center” will provide CSTLTS with increased stability moving forward and allow more active engagement so there’s a better chance of a more successful footprint with the work CSTLTS does with the field.
• José Montero explained CSTLTS’s cross-cutting work and how the center accomplishes its mission, including by developing standards and creating a system. This includes the creation of the Division of Performance Improvement and Field Services, which leads programs such as the Public Health Associate Program and also supports development of tools, resources, standards, and practices to strengthen operational performance and capability of STLT health departments. The division through its two branches working together, coordinates federal, state, and local partners to promote continuous quality improvement of state, tribal, local, and territorial (STLT) agency processes, programs, and services while building field capacity.

• CSTLTS supports the field in other ways, through managing the Preventive Health and Health Services (PHHS) Block Grant, the only flexible funding CDC provides. The block grant allows health officials to choose what their priorities are, and a large amount goes to public health infrastructure.

• If health departments are not using their funds to build infrastructure, they are not making lasting changes and need to figure out a better way to use funds—not just by filling positions and handling the issue of the day.

• CSTLTS manages umbrella cooperative agreements that can serve CDC as a whole, so other centers, institutes, and offices (CIOs) can use these mechanisms to fund partners.

• The reorganization created the Division of Program and Partnership Services, where CSTLTS is building teams to manage these funding mechanisms.
  o The division has two branches: the National Partnership Branch and the Health Department Program Branch.
  o The branches not only manage funding, but they also help to build capacity and change the ways the systems operate.

• CSTLTS provides technical assistance in many other ways, such as through the Public Health Law Program. CSTLTS looks at legislation and its role, including how it helps health departments build capacity.

• CSTLTS communicates with the health officials through products like Did You Know? and CSTLTS Director emails.

• A key part of CSTLTS’s cross-cutting role is to provide internal CDC coordination and support, such as helping to navigate things like requests from the Office of Management and Budget, helping to develop funding profiles, and providing internal consultation to other CIOs.

• CSTLTS’s role in public health emergency response has changed dramatically. CSTLTS has a clear role to help rebuild systems for the long run. In the aftermath of an emergency, CSTLTS helps manage funds through the crisis partner cooperative agreement. CSTLTS’s voice will be slightly different from those in other centers.

• By definition, CSTLTS is a cross-cutting center with whole-agency purview and is the entry point for health officials to CDC.

• We collect information from the field in formal ways (e.g., ATSDR/CDC Tribal Advisory Committee, STLT Subcommittee to the Advisory Committee to the Director) and in informal ways (e.g., seeing each other on site visits or at conferences).

• The needs everywhere are unique, so CSTLTS should figure out how to best serve the field and address needs especially as they relate to other CIOs.

Group Discussion on CSTLTS Update
• José Montero explained the process for approving the new structure.
• Emi Chutaro acknowledged that there has been a dramatic, positive change in conversations happening with CDC programs, though there is still a lot of work to do. She appreciates the creation of the Office of Insular Affairs.
Umair Shah asked what the thought process is for local-level people to see how CSTLTS’s work integrates back to programmatic work (e.g., as it would in a center for infectious diseases). Is CSTLTS working on activities that make sure local health departments are at the table with states, ensuring those most closely connected to a public health issues are represented? Health officials place a lot of trust in CSTLTS. How does CSTLTS ensure connections are appropriately made to locals?

José Montero responded that this is in process and made the following points:
- CDC is a big organization with funding constraints that are determined by appropriations language, and some centers are mandated to do only certain things.
- There is a tendency toward inclusion of cities and discussion in advance—better communication with the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) will help.
- There is an ASTHO call every two weeks when CDC can present and discuss local health department-specific issues; CSTLTS can bring updates to the meeting.
- Internally, each center operates differently. For example, CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention is conducting program visits. Dr. Montero engaged with them directly for those visits.
- Liz Davlantes, MD, CSTLTS’s Emergency Response Coordinator, attends all meetings regarding emergency preparedness and response.
- Every meeting with the territories involves the Office of Insular Affairs.

**Action Item**
- Share Dr. Montero’s slides, including proposed CSTLTS organizational chart.

**Social/Structural Determinants of Health Think Tank**

*Julie Morita, MD, Social Determinants of Health Chairperson*

Julie Morita provided an overview of last year’s Social/Structural Determinants of Health (SDOH) Think Tank activities. The SDOH Think Tank members—
- Have been working with the adverse childhood experiences (ACE) team to understand work being done at CDC and how STLT public health can do and promote ACE work
- Wrote a letter to the CDC director (signed by the full STLT Subcommittee) that highlighted the relationship between ACEs, health, social determinants, and opioids as foci for moving forward. The letter also drew the connection between ACEs and other priorities, such as HIV and hepatitis C, and provided suggestions for what CDC could support public health agencies to do:
  - Collect and analyze SDOH data: public health should link non-health data that relate to social/structural determinants of emerging public health challenges (e.g., opioids, HIV, hepatitis C) that can be defeated.
  - Convene multi-sector coalitions that support community-led approaches: public health agencies should bring together organizations that cut across traditional organizational boundaries to develop and test innovative solutions.
  - Expand existing CDC violence prevention approaches that address SDOH. These approaches prevent ACEs, which will, in turn, prevent a multitude of behavioral and physical health consequences.
  - Make available flexible and sustainable funding to support SDOH activities that affect ACEs to effectively reduce the impacts of Substance Use Disorder (SUD)-related morbidity and mortality.
**Recommendation:** Work with the CDC Director and appropriate CDC staff to ensure this focus is part of the opioid use disorder response, beginning with a discussion on this topic at this STLT Subcommittee meeting

- On August 1, 2018, a panel of SDOH Think Tank members presented work to CDC they are doing in their jurisdictions around SDOH. A common theme that arose: health departments have to be creative with funding to do this kind of work and they have to engage nontraditional partners.
- During the think tank meeting, it was encouraging to see the progress that has been made around SDOH over the years. The think tank’s recommendations have resulted in action, including creation of a vision statement and goals and proposed activities under the leadership of three cross-cutting offices (CSTLTS, the Office of Minority Health and Health Equity [OMHHE], and the Office of the Associate Director for Policy and Strategy [OADPS] (proposed)) that have been part of an SDOH working group for several years. The SDOH Think Tank will provide feedback on this work to help move CDC forward in its SDOH interests. It is good to see progress and opportunities that focus on families and not just individuals within funding opportunities.
- Selected responses to the recommendation adopted by the ACD in fall 2016 include
  - Early brain health and development initiative—SDOH is priority in how these issues will be addressed
  - Hi-5—will review five interventions to develop tools and training support for implementation
  - Injury, ACEs—CDC should play the role of convening federal agencies while also working internally on these issues.
- Progress seems disparate; the hope is to challenge Dr. Redfield to be the leader and champion for embedding, coordinating, and communicating SDOH work more widely across the agency.

**Recommendation:** Ask Dr. Redfield to be the champion of SDOH as critical to public health when he joins the STLT Subcommittee meeting later in the day.

**Group Discussion on SDOH Think Tank Update**

- The name of the think tank should remain Social and Structural Determinants of Health to capture critical concerns and to elevate the structural elements.
- Members would like to ask the CDC director to focus on that and to talk about the -isms, like racism, and structural root causes leading to certain disadvantages. The think tank would like Dr. Redfield to be the voice of CDC on these issues.
- Marcus Plescia: Should not forget the work of REACH, which still remains funded and constitutes significant SDOH work.
  - The think tank did not have a representative from REACH at the meeting but would be interested to have someone talk to them.
- All of the SDOHs are critical, and there needs to be a paradigm shift for CDC to accept this and internalize it agency-wide to be a good role model for all public health agencies to follow.
- People should not forget about women’s health and adequate preventive prenatal care.
- These are all important topics to bring up to the SDOH think tank or to the STLT Subcommittee. Topics don't have to go to the think tanks before they're brought to the subcommittee; they can come straight to the subcommittee.
- Future discussions should look broadly beyond SDOH to include other issues, such as climate change. If people think about situations like those in Puerto Rico and the US Virgin Islands, they will recognize that climate change affects the regular frequency of natural events and the quality and type of services available there.
• When approaching this topic from the data perspective, it is clear that work on the Surveillance Think Tank needs to focus on collecting nontraditional data, data that are not widely collected but are important for health officials and others to think about. Agencies must be able to provide metrics to support SDOH work. Integration across the think tanks is critical—think about the challenges and about novel ways to collect data.
• In addition to asking the CDC director to be the champion of addressing these issues, the subcommittee should recommend that he needs to elevate the work of the three CDC offices: CSTLTS, OMHHE, and OADPS. This working group should continue to collaborate as a core and should further be empowered to work across the agency to call out and promote this work.
• Leandris Liburd, PhD, MPH, MPA, Director, OMHHE, explained that her office is working regularly with colleagues in both offices. A few highlights:
  o She and colleagues are currently in the process of constructing an operating framework for health equity.
  o OMHHE concurs with the vision put forth by the SDOH working group for SDOHs as integral to public health and the pathway to achieving health equity. OMHHE is poised to work with internal colleagues.
  o The Health Disparities Subcommittee has provided a number of recommendations in the past in collaboration with the STLT Subcommittee.
  o Leandris Liburd is visiting states this year and hopes to continue that process this fiscal year to find out what work they are doing in health equity and how it is structured so that CDC can better align its work to support them.
  o CDC has a role as a champion for this work across the federal system and the many components of SDOH, all of which are important; a champion is needed to ensure all components are coordinated.
  o OMHHE has regular meetings with all of the directors of all federal agencies’ offices of minority health. The most current effort is to create a coordinated approach to find strategies that address the opioid epidemic with regard to minority communities.
  o There is a federal interagency health equity team with representatives from the departments of transportation, commerce, education, and housing. OMHHE attends those meetings.
  o Insular affairs:
    ▪ The federal interagency health equity group includes a liaison from Region 9, but there is a need to track from that representative to the insular affairs interagency working group.
    ▪ OMHHE should engage with that group (under Region 9 HHS—Pacific liaison office sits under regional director—the Office of the Assistant Secretary for Health [OASH]).
    ▪ The purpose of this group is to help reinvigorate what had been the HHS interagency insular affairs policy work, which has died down.
    ▪ Not all HHS programs are present in the Pacific. Asst. Secretary for Health needs to understand specific SDOH issues.
  o CSTLT’s internal lead for the Pacific area (Bill Gallo) is trying to build up coordination of work in the Pacific. Dr. Redfield is interested in building a relationship with the Department of Defense in the areas; follow up will happen with that option as well.
• PHHS Block Grant requirements allow health departments to spend funds on anything to help meet identified Healthy People 2020 objectives, including on minority issues.
• For HP2030, the number of indicators will be reduced to fewer than half. SDOH are part of foundational pieces that will be included.
  o HP2030 will keep SDOH but in a separate category. HHS is leading that work, but
discussions are ongoing.
  o CSTLTS is the CDC lead on HP2030 infrastructure goals; indicators around workforce
  and public health infrastructure are under development. Dr. Montero is a member of
  an outreach group for HP2030 and is trying to find out how to bring external
  stakeholders to weigh in.

• Georgia Heise: CDC needs to play a leadership role in SDOH using the cross-agency working group
to ensure CDC stays engaged; this should not just be across HHS.
  o Leandris Liburd is a CDC representative on the Federal Interagency Health Equity
    Team out of the HHS Office of Minority Health. There are monthly meetings, and they
    rotate departments where they hold the meeting.
  o The team does not create a national annual report, but the meetings are open to the
    public. Leandris Liburd will raise the question about how the equity team is reporting
    back out the work that they’re accomplishing.

**Action Items**

• SDOH Think Tank would like to learn more about REACH and how their [SDOH] work might be
  elevated. They will consider inviting a representative of REACH to the next meeting.
• Leandris Liburd will ask the Federal Interagency Health Equity Team out of HHS Office of Minority
  Health how it reports out the work its accomplishing.

**Recommendations:**

  o Support continued work and grow support of cross-agency SDOH working group
  o Ask Dr. Redfield to be champion of SDOH work within and external to CDC

**Public Health Surveillance Think Tank**

*Terry Allan, MPH, Public Health Surveillance Think Tank Chairperson*

• The purpose of the Public Health Surveillance Think Tank is to provide feedback and suggestions
to CDC leaders on key CDC and STLT challenges related to surveillance and informatics exchange,
with the goal of optimized ability for STLT public health agencies to effectively and efficiently
receive and use information to address public health needs.
• The think tank heard several presentations—
  o Dr. Chesley Richards, Office of Public Health Scientific Services (OPHSS), discussed the
    Surveillance Strategy Phase II.
  o Bill Brand, Public Health Informatics Institute (Task Force for Global Health), described
    self-assessment tools for health departments around building informatics capacity.
    ▪ Public health needs to know where it is to determine where it is going.
  o Ed Baker and Paula Braun talked about the Public Health Informatics Incubators
    Project—iSchools, which are schools that are creating informatics gurus who partner
    with STLT agencies to help them address critical informatics challenges
  o Some health departments have experienced loss of informaticians because they get
    recruited for other jobs that pay more than health departments. Incubators project
    may help address some of that challenge but not all of it.
  o Dave Ross, Taskforce for Global Health, described Vital Registration and Vital Statistics
    System Modernization, and how the lag in death data reporting to big pension
    systems around the country has resulted in a lot of money being paid out that they
    don’t receive back. Investing in modernization would save that money.
  o Bill Mac Kenzie, Center for Surveillance, Epidemiology, and Laboratory Services
provided Digital Bridge updates about pilots and testing portals. The support of state and local health departments remains crucial. They and all entities need to accept the concept of “One Public Health” wherein all entities need to agree to do things together to be more efficient and not work in silos. The think tank will continue to provide input and advice as needed.

Public Health Surveillance Think Tank Recommendations

The think tank offered several recommendations for consideration:

- **Recommendation 1**: Build on the significant progress to date by providing additional resources to operationalize the Public Health Data Strategy to position CDC as a global leader in using data to make informed decisions in real time to save lives by
  - Creating a data-science savvy workforce by significantly investing in efforts to build and recruit data science talent
  - Making data accessible and usable by readily sharing and linking data so that CDC, its partners, other collaborators, and the public can use it to its potential.
  - Create interoperable systems and tools to build an IT infrastructure that makes data sharing easier
  - Ensure that, through CDC’s leadership, partners are supported and coordinated so they can foster data-driven health improvements.
  - Ensure coordinated investments and governance across the enterprise to align data activities and resources for impact.

- **Recommendation 2**: Invest in the modernization of vital registration and vital statistics based on the recommendations from the National Committee on Vital and Health Statistics’ National Hearing on Vitals Modernization by Identifying, designing, and deploying a sustainable business model which
  - Simplifies processes and practices aimed at interoperability
  - Expands training for data providers
  - Integrates vital data collection into provider workflows, with accreditation as a possible tool
  - Provides templates for legislative actions to support this work
  - Deploys an application that collects and shares real-time data at the time of a death

- **Recommendation 3**: Invest in and build informatics capacity of STLT agencies in two ways:
  - Support expansion and increase of informatics capacity-building tools that have been field tested over the last four years (e.g., informatics savvy health departments and interoperability of self-assessments, and an informatics roadmap)
  - Spread and scale CDC informatics incubator programs in coordination with academic centers (iSchools) focused on building the informatics and knowledge capacity of STLT agencies to effectively integrate clinical, surveillance, prevention, preparedness, health promotion, and other relevant data to improve health

Group Discussion on Public Health Surveillance Think Tank

- Hector Gonzalez said that early data is critical to public health. CDC should examine where CDC can fund this vital registration/data initiative to bring in a new paradigm of epidemiologists, educators, and IT folks to speak together perhaps via the PHHS Block Grant. The Mexico/United States border needs data exchange as well through international systems, because to some jurisdictions (especially on the border), international data and domestic data must be interconnected.
  - Terry Allan suggested that Dr. Redfield and CDC could be a global health leader for this modernization.
• Mary Currier stated that initial efforts at CDC around data integration and electronic reporting and Digital Bridge are important, but the think tank needs to ensure that all subcommittee members agree with Bill Mac Kenzie’s efforts on Digital Bridge.
  o Terry Allan said that the Surveillance Think Tank will take that to heart.
• Emi Chutaro reminded the subcommittee that not all jurisdictions have equal existing capacity. Some jurisdictions have one health system, where labs are one unit and the only other providers are federally qualified health centers. It’s not just hospital and public health systems that need to integrate, it’s also interoperability among programs that have their own standalone reporting databases. For small health systems, it is challenging to maintain these systems and fix issues. The issue of interoperability keeps arising, but the burden of reporting and duplication of reporting make it difficult to make systems work together. There is not an easy solution, but there is urgency.
  o LaQuandra Nesbitt remarked that this is where STLTs are different but the same. There are very intentional things CDC does to help bolster workforce, and data scientists will be extremely important, not just project-based professionals. How can the subcommittee communicate to CDC that that STLTs need CDC’s help to address capacity needs to recruit and retain data scientists and IT people in the public health workforce?
• Chesley Richards thanked the subcommittee members for their recommendation and said there is still a lot of work to think through, but this surveillance data strategy can provide a framework to address
  o Workforce
  o Data (data policies that either facilitate common approaches or create barriers)
  o IT systems used to handle that data
  o Partnerships and how to get to a strategic level in discussing how to change the data enterprise
  o Governance and resources to get to a real enterprise approach—this makes or breaks it to coordinate or can’t get to the rest
• Chesley Richards endorses SDOH work and will do whatever he can as part of the data work to support inclusion of SDOH data.
• If there is going to be progress toward making CDC a state-of-the-art data organization and employ that data to accomplish the agency’s mission, CDC has to find a different way to think about resources.
  o Resources come through many different lines of funding, and many are attached to specific diseases, but there are common infrastructure pieces that are there to support that work. CDC has to satisfy congressional intent but won’t make progress unless the funds are used differently, and there is some flexibility to work across line items.
• STLTs should not be waiting on new initiatives before they try to make progress. The opioid epidemic is news. The foundation has been on mortality systems and syndromic systems to give more and more data to enable injury centers within states to think about how their opioid funding can be used to support these systems.
• One challenge at CDC has always been centralization and coordination of resources—programs don’t have the tools from that centralization that allows for some flexibility across programs; CDC has to go before Congress to ensure they satisfy congressional intent which can make such flexibility not possible. There needs to be a shift in how CDC and leaders can do a better job of thinking about this.
• There needs to be interoperability, first among federal agencies and then with STLTs.
  o People won’t realize the power of electronic health records until there is
interoperability.

- Public health needs to be involved with health care. Trusted Exchange Framework and Common Agreement (TEFCA) business agreements should be used rather than the current clinical providers and public health agreements. This would allow clinical to get certified into TEFCA and then interact with other systems. Public health needs to be at the table.

- There are three overarching messages:
  - One Public Health: Consider the view from the health care and health record creators—important for efficiency. One public health also relates back to capacity. Data savvy and building that IT capacity—the next five years are critical to the relevance of data sharing.
  - Support modernizing vital registration/statistics.
  - Think about STLT partners as incubators.

- This is analogous to the old genome sequencing. When forces in private sectors and large organizations have an incentive to understand population health, they will. Public health needs to be able to compete or won’t be at the table. Dr. Redfield understands this at a fundamental level and that will help him drive CDC in the direction that’s really needed.

**Action Items**

- Send Chesley Richards’s slides to the STLT Subcommittee.
- Identify ways to promote capacity building efforts related to iSchools, Incubator project, and informatics savvy health departments

**Public Health Finance Think Tank**

*John Wiesman, DrPH, MPH, Public Health Finance Think Tank Chairperson*

Think tank update

- There is a pending recommendation (adopted by the STLT Subcommittee) about funding getting into local communities, but with multiple CDC leader changes and changing priorities, the recommendation has not moved forward. It may be presented at the next ACD meeting, assuming the meeting is scheduled.
- There is activity happening, but figuring out what the think tank should work on has been difficult.
- The think tank members recommend that the think tank be put on hold until a more specific need is identified. The think tank members spent the May meeting talking about where they are trying to go but struggled with what would be a good use of their time.
  - Important things have been accomplished and progress has made, but think tanks don’t need to last forever.

**Group Discussion on Public Health Finance Think Tank**

- LaQuandra Nesbitt remarked that think tanks don’t have to continue after they achieve the established goals, which are often finite. There are other CDC committees. The way that public health gets funding in the United States evolves, so it is difficult to make recommendations.
- This Public Health Finance Think Tank may no longer be relevant. Other think tanks and projects include funding as part of their considerations, so people could discuss issues in those contexts.
- Umair Shah thanked John Weisman for chairing the think tank and stated that if he feels strongly enough, maybe it should be put on pause for now. Nonetheless, finance and alternate ways of working across state, local, and regional systems is absolutely critical to what STLTs do, so they need to find alternatives and to do this in ways that complement each other. Dissolving the think
tank doesn’t take away opportunities to work together on those issues.

- Umair Shah recommended not dissolving the think tank completely but to find ways to lower the threshold and reconvene it if needed. CDC needs to know what is happening in the field so the agency can make informed decisions at the federal level.

- José Montero stated that this is a perfect example of the type of discussion the subcommittee should have. CSTLTS is looking at ways funding can be flexible.
  - How do we convene people to get a STLT perspective and for what types of purposes in a pinch? This subcommittee might have the perfect representation.
  - Impact of STLT Subcommittee—Program Performance and Evaluation Office—policy and strategy show how over years CDC has listened to the field and changed the way notices of funding opportunities are issued and have incorporated language allowing for some flexibility. This grew out of the STLT Subcommittee’s recommendations.
  - We are trying to balance efficiency and still believe think tanks play an important role (e.g., SDOH within the financing realm—it’s not just money coming in, but it’s also where to use resources effectively). There are a lot of nuances the subcommittee can explore further if the think tank can tease them out.

High Priority Issue Update: CDC Response to Opioid Epidemic

Grant Baldwin, PhD, MPH, Director, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control

Selected highlights from the presentation—

- CDC is very interested in hearing perspectives from the field on how CDC investments are working to address opioid use disorder (OUD). Key leaders in the agency are providing feedback about how CDC is going to be responsive, but voices from the field are critical.
- CDC is trying to figure out how to bridge what we hear into an all CDC approach.
- There has been a high level of burden in the last six months. For example:
  - Drug overdose deaths have never been higher—there were more than 63,000 deaths in 2016. Two out of three of those (more than 42,000 deaths) were opioid related. There have been 350,000 opioid deaths since 1999.
  - There have been three reinforcing waves of the epidemic: 1) beginning in 1999: prescription abuse, 2) 2010: heroin, and 3) 2013: fentanyl + fentanyl analogs
  - US life expectancy decreased for the second year in a row since 2016. There is a projected decrease in 2017. This would be the first three-year decrease since the flu pandemic in 1918.
  - Unintentional injuries are now the third leading cause of death in the United States. They used to be fifth.
  - Fentanyl: During the first half of 2017, the proportions of deaths with any fentanyl analog or with carfentanil detected nearly doubled. States like Ohio were the hardest hit, with 20% of deaths involving analog fentanyl.
    - Need to watch the increase in deaths from other drugs contaminated with fentanyl.
    - Emerging concerns related to psychostimulants like cocaine, and deaths related to methamphetamine are increasing too.
- The North Star is to prevent opioid overdoses and deaths. CDC work complements work across the federal landscape. This epidemic calls for an all-in federal response—HHS (CDC, SAMSHA, FDA, HRSA) and Justice (BJA, DEA). CDC is trying to take this coordinated effort with others, including
public health, and public health safety net to a long-term recovery.

- There are five pillars in the CDC response:
  1. Data: Improve data quality and track trends and use data to drive action with populations and in communities most affected.
  2. State: Strengthen state, local, and tribal capacity to scale up evidence-based programs.
  3. Clinicians: Improve patient safety by giving providers data, tools, and resources they need.
  4. Public safety: With the shift in the epidemic, move from prescribing practices to strengthening partnerships between public health and public safety/law enforcement to identify threats and help link people to treatment.
  5. Consumer education: Empower the public to make safe choices; the “It only takes a little to lose a lot” campaign was designed to help with this.

- CDC is funding 45 states and DC through three distinct programs that make up Overdose Prevention in States (OPIS)
  - Prevention for States (PfS) and Data-Driven Prevention Initiative (DDPI) focus on enhancing and maximizing the use of PMDPs, insurer and community interventions, including CDC guideline implementation, evaluating state-level policies, and leveraging other innovative strategies that states can employ given the rapidly changing nature of the epidemic.
  - Enhanced State Opioid Overdose Surveillance (ESOOS) program focuses on getting data that is more real-time, more localized, and more actionable.

**Overdose Prevention in States (OPIS) Surge Support (S2) Funding for Fiscal Year 2018**

- This new funding opportunity is for $182 million and is intended to be a bridge for funds to get recipients from where they are now to transform data to action. The hope is to fund the 50 states, Washington, DC, and the 8 territories that are eligible to request additional resources to further activate prevention and response activities. The expectation is that this enhanced approach will allow recipients to more seamlessly bridge to implementation under a new multi-year funding award that will begin in Fiscal Year 2019.
  - The aim is to award funds in September 2018.
- A new $12 million notice of funding opportunity will fund many of the same kinds of activities, with $2 million going to tribal epidemiology centers.
  - Use data to drive action in very localized way
  - Prevention scope of activities: integrative approach to state and local needs, partnership, linkage to care, provider education/practice
- Public health is partnering with public safety—there is an overdose map tool intended to activate localized response and leverage law enforcement.
- Linkage to care peer navigators, policies to guide referrals, outreach teams, leveraging touch points
- Any door is the right door in substance abuse treatment. You have to get to the door.
- Implementing CDC prescription guidelines
- S2 is giving states some flexibility to work on evidence-based practice, evidence-informed practice activities, with some room for innovations.
- CDC is supporting 13 Combating Opioid Overdose Through Community-level Intervention Initiatives (COOCIlIs)
- Other parts of the agency are part of the opioid response; many people around the room can provide examples of other CIOs’ response activities.
Group Discussion on the High Priority Issue Update: CDC Response to Opioid Epidemic

- Discussions on this topic through the National Academies of Sciences, Engineering, and Medicine aim to ensure that local voices are heard. However, at CDC, when talking about the 45 states and Washington, DC, there are questions about when prequalified local health departments would be included in the process. Is there multi-year funding included later? Local health departments must be part of the solution, not only states. Sub-county data is critical, and the lack of it is challenging.
- The One Health concept should drive the response; there is anecdotal information with other parts of the health system, including veterinarians—people are going to vets to get medications for pets but then use the medications for themselves. CDC needs a broad-based approach to issues like these.
  - Grant Baldwin explained that S2 is one-year funding that is intended to serve as a bridge to carry health departments from where they are now to next year. CDC hopes to seed more localized activities going forward. CDC is using information about current activities being done with year-1 funding to inform S2 and use of additional resources with partners (e.g., NACCHO). Part of the reason why the focus is on bridging is that there are a number of large areas that would be interested in getting funding. Finding the right balance is vital, and the intent is to best represent all STLTs’ interests. The guidelines for implementation work must be used and interpreted in the optimal way. In the context of state-based efforts in health system implementation, indicators of progress are critical. A workgroup in the National Center for Injury Prevention and Control is looking at prescribing practices on a much more granular level and benchmarking. We need to ensure we provide care for people who are struggling with addiction so we do not have issues like those mentioned regarding veterinarians.
- Julie Morita voiced concerns about Chicago not receiving funds directly. States are not used to big cities not being funded directly, so the big cities have to work hard with the state to get the funding they need. Chicago has a high density of OUD.
  - Dr. Baldwin replied that CDC is very sensitive to this issue and is trying to figure out how best to address this challenge.
- Julie Morita referenced the STLT Subcommittee letter that was sent to CDC Director about finding ways to use opioid funds to incorporate ACEs and SDOHs. As we think about moving forward with consolidated and broader funding, these concepts should be included.
- Question: How involved is CDC with other federal agencies? Funding is not well coordinated with big cities. For example, SAMHSA and other federal agencies need to be involved in these conversations.
  - Grant Baldwin stated that the interagency principles meeting includes the HHS operating divisions and there is a behavioral health coordinating committee at the staff level. CDC can do better, and during the process of increasing staff since receiving first-time opioid dollars, some of that needed bridging has occurred. Some of the funding has already been dispersed and necessitates active collaboration. CDC is trying to build the response brick by brick, ensuring that data leads to action. There is a large menu of activities with an evidence base and much coordination with the Division of Violence Prevention. Some money has been allocated to piloting ACEs prevention as an approach to the opioid epidemic.
    - Melissa Merrick, PhD, National Center for Injury Prevention and Control: ACEs lead to later substance use and prescription misuse; we need to get to the next generation of those living in homes in these conditions. We need to address the conditions.
    - We are learning from the Martinsburg initiative, which is a collaborative
between police and schools; there is a lot of literature on trauma and substance abuse disorder and necessary partnerships, both traditional and nontraditional. We are attempting to grow this intersection in all of our work.

- Grant Baldwin stated that under Dr. Frieden’s leadership, with development of related violence technical packages and is supporting states to implement the recommendations in them.

**Emerging Issue: Suicide, Its Underlying Factors, and What States and Communities Can Do**

*Deborah Stone, ScD, MSW, MPH, Suicide, Youth Violence & Elder Maltreatment Team, Division of Violence Prevention, National Center for Injury Prevention and Control*

Selected highlights from the presentation—

- Dr. Stone presented *Vital Signs* objectives, data, and methods for collecting it. Data highlights:
  - 45,000 lives lost in 2016
  - 30% increase in half of states since 1999
  - Rates increased in almost every state
  - 54% of people who died from suicide had no known mental health condition
  - 2015 data in 27 states: Most were between 25 and 64 years old (69%), male (77%) and white (83%)
  - 48% suicides by firearm

- She provided examples of what can be done (see “Preventing Suicide: A Technical Package of Policy, Programs, and Practices” with seven strategies that can have broad population impact) and explained CDC’s approach to suicide prevention
  - This includes the use of a public health approach inclusive of upstream and downstream types of interventions

- The federal government is
  - Tracking the problem to understand trends and the groups at greatest risk
  - Developing, implementing, and evaluating suicide prevention strategies
  - Supporting STLTs and other partners to prevent suicide

- States and communities can
  - Identify and support people at risk of suicide.
  - Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
  - Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
  - Offer activities that bring people together so they feel connected and not alone.
  - Connect people at risk to effective and coordinated mental and physical healthcare.
  - Expand options for temporary assistance for those struggling to make ends meet.
  - Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

- The healthcare system can
  - Provide high-quality, ongoing care focused on patient safety and suicide prevention.
  - Make sure affordable and effective mental and physical health care is available where people live.
  - Train providers in adopting proven treatments for patients at risk of suicide.
• Employers can
  o Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
  o Encourage employees to seek help. Provide referrals to mental health, substance use, legal, or financial counseling services as needed.
• Everyone can
  o Ask someone you are worried about if they’re thinking about suicide.
  o Keep them safe. Reduce access to lethal means for those at risk.
  o Be there with them. Listen to what they need.
  o Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
  o Follow up to see how they’re doing.
  o Find out why this can save a life by visiting: www.BeThe1To.com.
• The media can encourage people to seek help and avoid increasing suicide risk by not using dramatic headlines or providing explicit details.

Group Discussion on Emerging Issue: Suicide
• The Substance Abuse and Mental Health Services Administration (SAMSHA) is working to ensure that behavioral health screening is taking place in emergency rooms and primary care settings as initial detection spots to make sure people do not fall through the cracks. There is a lot of work to be done.
  o The Division of Violence Prevention is funding UC Davis and the University of Maryland, Baltimore, to develop and test innovative interventions designed to support middle-aged males at risk of suicide.
• Emi Chutaro: The territories don’t have an opioid crisis, but they do have a methamphetamine crisis in some jurisdictions and some of highest substance abuse statistics globally.
  o In terms of capacity for provisions of services—there is one clinical psychiatrist for all six jurisdictions.
  o The territories have the highest recruitment rates from the military, so many of the returning veterans have issues, including PTSD and high suicide rates.
  o Because there are not a lot of local services available, they would have to travel far for care.
  o Yet, they are resident aliens, so they are not eligible for transportation to Hawaii even though they served in the military.
• This is a significant health equity issue in the territories; don't lose other opportunities for the islands.
• Deb Stone:
  o CDC is very concerned about the territories and has published a notice of funding opportunity related to this topic.
  o CDC is providing support to Puerto Rico to help provide services and help connect people to services and reduce the risk of suicide.
  o CDC is also conducting an environmental scan of all 50 states and territories and select tribes to learn about the factors that may be associated with increasing suicide rates.
• Terry Allan: Do we know the proportion of suicides related to bullying?
  o Deb Stone: bullying as a relationship problem is a factor and is associated with youth and certain minorities. There are strategies in the technical package to address those kind of relationship problems. She will try to find the exact number or proportion of suicides related to bullying.
Bullying is not a discrete circumstance collected by the National Violent Death Reporting System (NVDRS) and suicide is usually associated with more than one factor. According to the NVDRS in 27 states in 2015, youth aged 10–18 had the following circumstances associated with their suicides. Bullying may have been linked to some of these:

- History of attempts=22%
- Crisis in past two weeks=33%
- Intimate partner problems=22.8%
- Other relationship problems=7.9%
- School problems=20.3%
- Alcohol problem= 2.6%
- Other substance problem=8.9%
- Criminal/legal problem=6.9%
- Job problem=1.4%
- Other circumstances=17.9%

In one study of 482 youth aged 11–15 who died by suicide, 9% of NVDRS cases mentioned bullying, specifically as a factor associated with suicides.

  - Melissa Merrick: This is broader from the perspective of ACEs and beyond in that the experience of bullying and relationship adversity do create compounding challenges over time.

- Julie Morita: Strategies outside the box are needed for suicide prevention. States that have more generous unemployment benefits tend to have lower rates of suicide, and other financial security measures are also linked to lower suicide rates. Stabilizing housing will help reduce the risk of suicide. Yet, there is no plan about how to implement such strategies and no line item at CDC. Using discretionary funds to get some of these programs up and out might be helpful.
  - Deb Stone: Delivery platforms (e.g., telehealth) for areas where there is a shortage of providers is one of the strategies in the technical package. Rural areas have rates that are particularly high and increasing.

**SUGGESTION:** Members should think about how the subcommittee and think tanks should engage on these topics moving forward. Is it appropriate for public health to take on this role, how would this work involve CDC, and how would the work be coordinated?

- LaQuandra Nesbitt provided a thought for consideration: Remember that all members were asked to join the subcommittee because of their roles as health officials. In that capacity, they wear “big hats” but they also wear “little hats” and come with very specific areas of expertise and specific goals and objectives. Wearing their big hats requires coming with broader goals that all members have for population health and public health. It would be encouraging and productive if members could put their big hats on for their discussion with Dr. Redfield so their years of expertise can help move these conversations forward.

**Action Items**

- Deb Stone will look for numbers related to bullying and suicides.
- Consider how the STLT Subcommittee can help CDC better address suicides.
Emerging Issue: Public Health and Mental Health

Ileana Arias, PhD, Acting Principal Senior Advisor to CDC’s Deputy for Noncommunicable Diseases, Injury, and Environmental Health

Jennifer Kaminski, PhD, Team Lead, Child Development Studies Team, Child Development and Disability Branch, Division of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities

Dr. Arias opened this section of the meeting asking for feedback from the STLT Subcommittee about how CDC can improve its work around mental health to date. She offered some background of CDC’s work in this area, some questions and challenges. Selected highlights from the presentation—

- It is difficult for public health and CDC to manage addressing mental health per se because mental and behavioral health can be either a preceding, co-occurring, or consequential event of physical health.
- Although prevention is core to CDC work, mental health has been addressed typically by CDC or the mental health field from a prevention perspective—prevent developing mental health problems or preventing its impact on health.
- There is a significant challenge in moving the dial in this work at CDC because there is not a unit dedicated to mental health. There are workgroups across the agency that engage in the work, but CDC is trying to create a program/programmatic approach.
- Progress too often stops with “And then what do we do?” because the workgroups do not have the same structure or charge that a unit would. This makes it difficult to identify what has been missing, what CDC should do, and what broader public health should do.
- The outcome of what is done is also unknown. It could be to prevent minor psychiatric disorders or major psychiatric disorders or it could be something more generic. It could be well-being, which is the ability to cope with stress in a way so that it does not lead to mental health or physical health problems. How are people taught to manage that?
- If there were clarity about an outcome, then it would be easier for CDC to identify outputs to get to those outcomes, what resources would be needed, and how the resources could be obtained.
- People bring different perspectives that stem from their own work, but those perspectives might not lead to the ideal outcomes.
- External issues also affect identification of outcomes—sister agencies address pieces of mental health, and all agencies are convinced that they do prevention. But do they?
- There needs to be a population-based perspective—what can move the entire population, not just individuals?
- After outcomes are identified, a workgroup would not suffice to do the work without a dedicated unit, funding, and leader. There needs to be outcomes, structure, accountability, and external interest.

Dr. Kaminski presented about promoting children’s mental health. Selected highlights from the presentation—

- It is difficult to know how prevalent children’s mental disorders are because there is no single definition that could be used for surveillance.
- If mental health is viewed as the mental, emotional, and behavioral capacities in children that equip them to function well where they live, learn, and play, then all children have mental health.
It is a capacity that can be built, nurtured, and protected, and public health has a role to play.

- Public health should care about children’s mental health because it relates to many health indicators, and some child mental health and mental disorder interventions also show impact on longer-term outcomes.
- Promoting the good things that can have a positive impact are as important as preventing the negative factors that affect mental health. It is important to focus on both sides of the equation, identify potential high-level opportunities, and develop evidence and tools where that work can happen even with limited funding.
- The National Center on Birth Defects and Developmental Disabilities’ activities around this work intersect with STLT Subcommittee think tank interests:
  - Surveillance: Analyzing national survey data and healthcare claims data; estimating prevalence via community-based assessment; investigating small-area data estimation as a way to increase the local utility of national survey data; building state capacity to monitor children's mental health and facilitate early identification and referral to services. For this work,
    - Year 1: Develop roadmap and Year 2: Engage interested states.
  - SDOH: Identifying potentially modifiable family, neighborhood, and healthcare risk and protective factors; facilitating system uptake of evidence-based parenting programs (early childhood education, community-based settings, healthcare system); and characterizing and evaluating policies that influence SDOH and parenting (economic security and housing)
  - Finance: Characterizing and evaluating healthcare financing and payment policies; facilitating uptake of value-based payment approaches:
    - Evaluating a high-reach, lower-cost program to teach evidence-based parenting skills
    - Supporting development of pediatric health system performance metrics
    - Building a business case for redefining “value” at the family unit
    - Developing a field guide to help states move to value-based pediatric behavioral health care

**Group Discussion on Emerging Issue: Public Health and Mental Health**

- Hector Gonzalez: This is a complex but appropriate issue to discuss. Though there are different umbrella agencies at the local level, they have no choice but to respond to mental health issues in a community, especially when looking at some communities that have to provide all services where there is no one else to provide them. Yet the problem of behavioral health is increasing. Therefore, it is vital to integrate mental health screening into services. However, when there is a problem, where do you send it? Do local health departments have any choice, and how do they develop those procedures? There needs to be more concentration on the positives for children and look for their assets, curiosity, etc., but do not forget the basic like housing.
- Nicole Alexander-Scott: I applaud the mention of policies and the more we can do that with a community focus mindset, incorporating mental health in public health, the better off we are. ASTHO’s President’s Challenge has elements in addition to community-led focus and investing—elements of connectedness and communities coming together and community resilience. Silo concerns exist within our agencies as it relates to SAMSHA. The question about roles and crossing silos comes up. While we are drawn to wanting to overcome those silos, there is so much work to do to avoid stepping on toes. We need to be able to tackle this. How can the subcommittee help and push that? The same challenge Dr. Kaminski described is what state and local health officials face.
Principles to consider:

- Identify something that overlaps as little with what is being done by sister agencies (in terms of activities or intent of what is being done, such as mindfulness work).
- Identify what can happen at the population level, after which SAMSHA can integrate into what is done.

LaQuandra Nesbitt: I see this in terms of health departments and our health department role. Much depends on whether a health department has behavioral services in its purview or not, which affects how we think about behavioral health/physical health investment. We often think about home visiting for maternal and infant health. For example, what about parenting support juxtaposed to these home visits for improving mental health? Financing treatment of mental disorders/treatment gets tricky like financing health care in health departments. There are clear examples of what public health does every day in mental health. We must find ways to do work collaboratively without getting into turf wars.

Mylynn Tufte: Technology is transforming everything we do and especially children’s behavioral health. CDC has an opportunity to take a leadership role as far as preventing, detecting, and responding. Look at this from surveillance lens.
- CDC has not published guidance for states, parents, or clinicians around how much technology kids should be exposed to, nor is there a public health message or message for parents related to technology use by children. CDC can currently only point to the American Academy of Pediatrics recommendations.

John Wiesman: It is about public health being its best chief strategist. How do you think from a systems perspective we can integrate mental health into public health practice? What are the needed policies? Supporting the chief health strategist role is a place to start. Suggest pushing back on idea of dedicated funding for this work. At this table, we have said we do not want more line items for new areas but rather we want flexible dollars. We also need workforce trained to play role as chief health strategist to address these issues. A toolbox would be helpful.
- Jennifer Kaminski may have some tools to share with group.

Julie Morita: An example where we can leverage existing resources—maternal and child health (Health Resources and Services Administration funds). There is a good opportunity there to address parenting-related problems. Expectations could be set to address mental health needs within that block grant.

José Montero: What is it we are after when we are talking about mental health vs. the whole universe of different activities? Are we missing the spine? Is that what we want? We know what science tells us. Do we know how effectively we are measuring? How do we from public health body help? Are we just purveyors of data or are we promoting an agenda so mental health is not just mental disease? We need subcommittee’s help thinking about that.

Umair Shah: We need a higher level look at these issues. One challenge that is hard to appreciate is the broad spectrum of where mental, behavioral health resides. Can public health raise awareness and educate about the importance of these issues? In Texas, we are asking whether mental health is more of a chronic disease. There are acute consequences and needed resilience within midst of emergencies. We cannot just have a scientific way of thinking but rather need a broad-based perspective. Resilience is a good way to frame it and move our work forward. We should have that broad-based perspective even if at the end of the day, policies and funding do not come into the public health sector. We just must keep state and local health departments at the table. This goes across the spectrum of chronic and acute disease. When there were challenges around Ebola and Zika, there was a dual challenge of getting our arms around people who were really at risk. With opioids, we see this has affected people across all spectrums of society. Moreover, are mental and behavioral health the same thing? We need Congress and...
others to act as champions. This is affecting almost all of us. It is important to engage very, very robustly.

- LaQuandra Nesbitt: Sometimes in public health, we should be more introspective and sometimes more humble rather than seeking a pat on the back. Hopefully, CDC and public health can serve as an example when it comes to policies related to mental health given the level of maturity public health and CDC has in this space compared to SAMHSA and the mental health community. There is still a lot of disparity and lack of access when it comes to mental health. Unlike physical health where a shift to advocacy for some population health and policy-level change has occurred, much of the advocacy for mental health services still remains largely focused on access to services. We should think about policy-level changes for mental health as well.

**Action Item**
- Review discussion at this meeting to determine options for supporting mental health work at CDC.

**Discussion with CDC Director Robert Redfield, MD**

- Dr. Robert Redfield, MD, director of CDC, welcomed committee members and invited them to ask questions.

**Comments/questions among STLT Subcommittee members and Dr. Redfield**

- Julie Morita, chairperson of the SDOH Think Tank, thanked Dr. Redfield for acknowledging a letter the STLT Subcommittee sent to him. It is clear that the cross-CIO work on this effort is critical and that there must be a champion for SDOH across the agency or we will not be effective.

- Dr. Redfield
  - Has been talking to Surgeon General VADM Jerome Adams, MD, MPH, about how the medical community has to take some responsibility for the opioid epidemic.
  - SDOH are the new fifth vital sign, and there is a need to have a standard assessment for this vital sign. It is much **more** likely that SDOH can affect health. Evidence-based data should be used to include the fifth vital sign.

- SDOH is really important and underappreciated. People see this now with the opioid epidemic, but the reality is that it was important before. How do we get the average health system to recognize this is as important as pulse and blood pressure?
  - Wants CDC to take on its role in the opioid epidemic and HIV and make meaningful progress.

- Dr. Redfield: This is a time to define SDOH as critical, and SDOH needs to be integrated into the practice of medicine.

- CDC may have a role in helping to make sure the resources are available, but the STLT Subcommittee members’ agencies are representative of the public health infrastructure.

- Dr. Redfield: The Strategic National Stockpile is likely to be moving out of CDC, but this needs to happen in a way that doesn’t compromise public health. CDC has a critical role in knowing what the countermeasures are as this function is separated from the rest of the emergency response system that CDC has mastered.

- The STLT health departments’ relationship with CDC is extremely valuable, and CSTLTS is the nexus to CDC.
  - Health Official Orientation was very helpful for navigating CDC.
  - CSTLTS’s goal is to support health departments, and the center is receptive to think tank and subcommittee input.
• Nicole Alexander-Scott
  o Thanked Dr. Redfield for his commitment to championing SDOH and acknowledged that CDC has made significant improvements in addressing SDOH.
  o Work is beginning to shift from investments in healthcare settings to include communities. There should always be two approaches to addressing SDOH: 1) through clinical settings, (as the new fifth vital sign) and 2) directly through the community. The structural determinants of health need to be elevated when doing SDOH-related work.
  o CDC should be the chief health strategist in helping other federal agencies engage in this work.
  o Language in notices of funding opportunity needs to shift to help health departments better implement SDOH work.
• There are 120 different data systems at CDC that don’t talk to each other. In that vein, driving change around public health data strategy is critical. Questions to be answered:
  o What do we need, what resources for interoperability or for a data-savvy workforce?
  o How do we actualize the concept of One Public Health, both internally and externally? We need to have capacity throughout the enterprise to interact with data effectively, and we require significant resources to do that.
  o As a way to build informatics capacity, CDC should promote the concept around informatics incubators.
• Dr. Redfield stated that it is healthy for CDC to have outsiders like the STLT Subcommittee members come in. He aims for CDC to be stronger when he leaves than it was when he came, including improvements to data systems.
  o CDC and STLTs need to be the best of the best at handling data, and our systems haven’t kept up. Instead of creating a system as part of an overarching strategy, many of the systems were created by individual programs when they needed to do something immediately. The opioid epidemic is a crisis with an opportunity to collect data as part of a strategy. There are new attempts to move syndromic surveillance away from “the doctor calling the health department to check a box.” If we can show that we can operationalize a more coordinated response in how we collect data on opioid-related events, then we can make a real difference on the public health approach and simultaneously convince people that it has value. The onus is on CDC.
  o There are not enough people in the workforce who understand this information space. CDC needs a strategic partner to make sure we have the best technology (e.g., you don’t partner with a bicycle company when you want to make an airplane).
  o Robert Redfield: It’s important to have a mechanism to respond in real time.
  o Lawmakers should invest in technology the same way they would for a new pathogen. There must be an argument to escalate this information infrastructure; using the opioid epidemic may be the best opportunity as public health transforms from pen and paper to real-time, multi-system data.
  o The real future isn’t to present historical data from two years ago, it’s for CDC to predict what’s coming with predictive analysis. The agency can’t do that without data. The opioid epidemic might be the vehicle for change.
• Basic core capacity at STLT and federal levels is necessary to do the work. There is an invisibility crisis as far as public health is concerned; people still do not understand what happens in public health.
• Umair Shah offered that anything the subcommittee, ASTHO, or NACCHO can do to help, they are there to support CDC to be successful.
• Robert Redfield: STLTs and CDC make the best impact by all working together. There needs to be a
public health solution that is available to the public for preventable health crises. He added:

- CDC needs help with innovations in chronic diseases, hepatitis C, and HPV.
- We need to increase vaccines and get vaccinations up in general, but public health doesn’t message this well. For example, you don’t tell the public, “They work only 36% of the time.” Rather, you say something like, “They prevent morbidity and mortality at high rates.”
- Public health is silent when we prevent diseases because we aren’t measuring prevention, and then people can’t see the negative impact of disease because it isn’t there. The way to counterbalance this is by taking one or two prevention approaches, then focus on the feasibility of them and what they can accomplish.
- We must also realize that we can’t do everything at once or we end up accomplishing nothing. It is always difficult for public health leaders to decide what to choose as priorities.
- I would like to hear from the subcommittee members what they believe are the first three priorities, second three priorities, etc. My current top priorities include HIV and increasing immunization rates.

- Hector Gonzalez: With everything that has been discussed, some fundamental issues remain and cannot be forgotten, such as maternal/child health. In this area, public health is playing an important role with partners when people aren’t insured. For example, what are we doing with agencies to ensure every woman has access to maternal and child healthcare?
  - Dr. Redfield: This is an extremely important area. You have to pick something you know you can win and have a path, trying to find the gaps. There should be an attempt to have incremental improvements in this area. If problems are going to be solved, we have to work collectively with different agencies playing different roles to achieve a common goal. We should not underestimate the possible.

- John Wiesman: Thanks to Dr. Redfield for the simple and direct communication with STLTLT leaders.
  - The STLTLT Subcommittee has adopted a recommendation related to optimizing CDC funding to reach across the public health spectrum, but the ACD has not met to formally adopt the recommendation. This is an outstanding recommendation on which the ACD or the Director should move forward.
  - Consider writing an article about SDOH as the fifth vital sign, though one must anticipate criticism from different parties.

- CSTLTLTS remains an important lifeline for STLTLTs into CDC. It helps cut across bureaucracies and has changed the course in the country for our practice.
- Mylynn Tufte: The aspirational and transformative nature of technology is important and the payers have made the investment. CDC must partner with payer community to help achieve the mission.
  - Dr. Redfield: The healthcare system, payer community, and third-party payer systems must all be part of the discussion. I fully agree with suggestions related to technology.
- Julie Morita: The STLTLT Subcommittee members encourage CDC to strengthen and support the work as a group. The STLTLT Subcommittee is incredibly valuable to its members, and we invite Dr. Redfield to take advantage of our input.
  - Dr. Redfield: I fully intend to do that. The balancing act in this role is my challenge, but I understand it is extremely important to get input from this group.

**Action Item**

- Dr. Redfield challenged the group to 1) name their top 10 public health issues, 2) tell him what tools they need to solve those issues, and 3) once the tools are defined, suggest which ones make most sense to get the public support. He would like to see a “social autopsy” of
leading public health issues (e.g., why overdoses in certain places or populations, why people do not get vaccines) and then design intervention strategies to address the real issues.

Strategic Planning Discussion

Questions for Consideration:

- Purpose/Mission of STLT Subcommittee: Is it still appropriate or should it change?
- Criteria for focal points of subcommittee work
  - Are the think tanks the right ones?
  - Are the think tanks working to or addressing the STLT Subcommittee mission?
- Emerging cross-cutting issues for consideration
  - What should they be?
  - Should there be a routinized way to discuss them
  - Infrastructure: Is it working?
- Member perspective: Does time spent in STLT Subcommittee meetings, including think tanks, add value to your work and mission as a public health leader?

Responses

- Terry Allan: In the Surveillance Think Tank, there have been a lot of discussions about capacity building, and Dr. Redfield has shown interest in strengthening capacity. There is clearly a need for new kinds of informatics staff. This ties back not just to CDC, but also to the health/public health enterprise. Perhaps the name of the think tank should evolve to reflect some of this focus and not sound like it is just focused on surveillance and data systems.
  - SUGGESTION: With the disbanding of the Finance Think Tank, remaining think tanks should consider funding strategies for cross-cutting data, like data on SDOH.
- Nicolas Barton: The tribal perspective and how the United States is overlaying on Indian Country is so important. A lot of history colors perspective about tribes and CDC’s role. Tribes are their own nations and have different levels of health concerns. There is a lot of work to do in tribal nations and territories. Putting on my “big hat” thinking—we should think about policies that put too much focus on the Indian Health Service (IHS) as a big catchall for all health challenges, which isn’t fair to Native Americans. CDC programs are just getting started in Indian Country. Partnerships are the key because Indian health is everywhere. CDC should look to tribes as key partners to advance health. Tribes have similar data access challenges as have been discussed in health departments and CDC. CDC should seek opportunities to advance resources and funding opportunities for data and technologies in tribes, with an emphasis on working collaboratively with public health (e.g., bulk buying of technology through IHS).
  - SUGGESTION: With the disbanding of the Finance Think Tank, remaining think tanks should consider funding strategies for cross-cutting data, like data on SDOH.
- The STLT Subcommittee in-person meetings are a good opportunity to hear what’s going on. One day is hard to crunch everything in, so many favor a longer time to process in the meetings, meaning meetings that are longer than a day.
  - SUGGESTION: Make meetings a day and a half to take some time to process what is discussed.
- Umair Shah: It is challenging to manage the different “big hat” and “little hat” thinking: large urban county, state of Texas, NACCHO, etc. All of those perspectives and the challenges they face are important. It is hard to figure out who I am supposed to be representing at these meetings. How do we find a way to get beyond the jurisdictional piece or community context? What do we need throughout the system? It would be helpful to have a better definition of what perspective we should bring so we can better understand how to answer, review, and consider any of the topics discussed.
LaQuandra Nesbitt: There is no expectation that a subcommittee member doesn’t represent his or her jurisdiction per se. The barrier to overcome is not taking advantage of a particular position, but trying to focus on a collective experience we could think about as a whole to help address common issues. You could verbalize a perspective on behalf of large urban cities, but all of the things you represent have to be brought to the table. A large urban cities perspective shouldn’t be only thing bringing you to the table. For example, this subcommittee presents an opportunity for public health to think collectively about how SDOH should be worked into categorical funding for disease. The subcommittee could improve how it thinks strategically.

- Each subcommittee member was carefully selected for his or her expertise. Members are not expected to advocate for their specific jurisdictions, but rather for the collective experiences that represent the picture of public health across the country. The subcommittee provides collective advice, though the director will not always take it depending on whether the advice is within the agency’s scope, mandate, and budget constraints. There are things CDC can and can’t do.
- Umair Shah: Longitudinal activity is good, too; it helps to be on the subcommittee for longer than just one year.
- José Montero: If this subcommittee commits to three days, we will figure out how to make it happen, but at the same time, we want to be respectful of members’ time.
- Julie Morita: We can come to this table with our “little hats” but when we go to the CDC Director, we need to wear our “big hats.”
- Nicole Alexander-Scott: I very much value this subcommittee. I appreciate the think tank process and the letter we wrote to the Director. We may want to rethink how the think tanks and subcommittee work together.
  - **SUGGESTION:** Consider a think tank format that includes addressing what the Director challenged subcommittee members to do. We need to respond to him because he asked us for help.
- Hector Gonzalez: These meetings have provided valuable information and plans. I agree we might relook at the think tanks and how they move forward. They are not necessarily bad or wrong, but we should move to phase two and consider how to build capacity to implement the recommendations coming forward. We might look at cross-cutting issues and see what else is missing.
- LaQuandra Nesbitt: The think tanks are the right infrastructure to move work forward. It makes sense to disband the Finance Think Tank for now. SDOH and Surveillance Think Tanks are operating at very high levels to move critical topics forward. If we add think tanks, we should consider how they align with core capabilities the CDC Director wants to focus on. As he works on those topics, those topics can cut across our think tanks. We should ask if there are others to stand up that would focus on those core issues (e.g., workforce). We might consider topics that merit the resources and time investment. They can be short- or long-term. We may consider a think tank focused on public health infrastructure through which many topics might be pushed. We should also find a way to take on any emerging issues like those we've heard about today.
- Emi Chutaro: We might consider an additional think tank focused on health security, which is broad and includes surveillance. Also, health security includes external threats. We must be cognizant of internal threats.
  - **Recommendation:** Consider establishing health security as a new cross-cutting think tank.
- Terry Allan: It is a good idea to invest in infrastructure around data. There could be a request
for real-time input in terms of use of funding as it ties back to workforce. Perhaps there is value in thinking about workforce independently because it has implications for public health in a variety of contexts.

- Nicolas Barton: In response to the Director’s request to us: Do we know our top 5 and top 10 problems? Note that if everything is a priority, nothing is a priority. As a subcommittee, how do we think about the resources that CDC has? There is no strategy for surveillance, which is needed.

- Georgia Heise: The relationships between the different letters in STLTs need some focus.

- LaQuandra Nesbitt: If the surveillance think tank transitions into health security and encompasses infrastructure broadly, we need to think about very concrete goals. Think tanks might have utility over a 2–3 year lifecycle. We should also try to align think tank work with NACCHO or ASTHO’s work.

- Global health intersects with domestic health. This is important to integrate in our discussions.

- Subcommittee members should not forget Dr. Redfield’s comment about his priorities. If the subcommittee’s role is to guide CDC, members need to advise him on those topics. This is an opportunity to inform and guide how it plays out. Members want to be part of the discussion of his priorities to guide these.

**Action Items**

- Set up time in next few weeks to think about multiple recommendations or proposals from this discussion.
- Consider a mechanism to respond to Dr. Redfield’s challenge.

**Public Comments**

- There were no public comments.

**Summary Comments**

- Members appreciated having representatives from NACCHO and ASTHO attend the meeting.
- This was a productive meeting. Members should move beyond talking about SDOH and engage CDC with SDOH and see that it flows out to the STLT health departments in tangible ways through notices of funding opportunity and other mechanisms.
- The subcommittee appreciated having the tribal perspective.
- The subcommittee might be missing opportunity to communicate what “boots on the ground are doing.” At the higher level, it’s encouraging to hear about the support to address the opioid epidemic response. But this would be an opportunity for people with boots on the ground to say that they’re seeing an increase in meth use.
- John Wiesman: We need the ability to balance what CDC, CSTLTS, or other CIOs need from this group. It is also important to continue to bridge across the federal government, as well as hearing about practices in the field. We haven’t been great about listening to these points of view. Do we allow the right space for these sorts of perspectives? If the ACD doesn’t meet for a while, there is a question about whether recommendations from this group will be meaningful.
- The discussions were all formatted very nicely around SDOH, and it was encouraging to have Dr. Redfield’s support.
- The work the subcommittee is already doing is incredible and exciting. Now comes the implementation work.
- Emi Chutaro: With HHS meetings, I have used this subcommittee as a model. Thanks to CDC
for hearing what we are saying. I have a lot of questions now: What can I do in terms of my work, and where can I be of assistance in those conversations with HHS? How can we make CDC work better for some of us? CDC is moving away somewhat from the frontline work, but in rural, isolated areas, there is a need to revisit what can be done. It is important to be advocates for each other. To do that, we need to step in each other’s shoes.

  - Suggestion: Go offsite to meet providing context for others’ perspectives.

- Umair Shah: There is a lot of opportunity to think about which “hat” we bring to the table. It may take a longer time if we go offsite, but that would also provide a real understanding of our issues as a pilot case to bring up. There is not enough opportunity to bring up what you’re really facing in the field and would benefit from discussion in this group together.

- Nicolas Barton: “We didn’t cross the border, the border crossed us”—we need to find ways to support and promote primary prevention (e.g., immunizations). Everyone needs funding, resources, and people.

- Terry Allan: This is a public health family. We should try to align how whatever we are thinking about matches up with Dr. Redfield’s vision.

- While face-to-face meetings are costly, there is real value in the interactions and relationships. These meetings are so important.

- Members should invite CDC to their jurisdictions so CDC can continue to learn.

- Members need to be proactive about reaching out to CDC rather than staying reactive in response to CDC requests.

- It is good for senior CDC leaders to hear what the subcommittee members have to say. Dr. Redfield told us what he want us to advise him on. We need to deliver and figure out how to do that. We may need to pick and choose.

- Members would like to try to meet in person more than once per year.

### Initial Action Items

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<td>All</td>
<td>Consider a think tank format that includes addressing what the Director challenged the STLT Subcommittee to do</td>
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| STLT Subcommittee Steering Committee to initiate | Set up time in next few weeks to think about multiple recommendations or proposals from this discussion  
  - Consider mechanism to respond to Dr. Redfield’s challenge |
| Judy Lipshutz              | Share Dr. Montero’s slides with the proposed CSTLTS organizational chart |
| SDOH Think Tank            | Learn more about REACH and how their [SDOH] work might be elevated |
| Leandris Liburd            | Ask the Federal Interagency Health Equity team out of HHS Office of Minority Health how it reports out the work it does |
| Judy Lipshutz              | Send slides presented by Dr. Richards to the STLT Subcommittee |
| Deb Stone                  | Look for numbers related to bullying and suicides |
| All                        | Consider how the STLT Subcommittee can help CDC better address suicides |

### Next Meeting: TBD