



Minutes from the
April 16, 2014

CDC Advisory Committee
to the Director
Health Disparities
Subcommittee

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Advisory Committee to the Director Health Disparities Subcommittee Record of the April 16, 2014 Meeting

The Centers for Disease Control and Prevention (CDC) convened a meeting of the Health Disparities Subcommittee (HDS) of its Advisory Committee to the Director (ACD) on April 16, 2014, at CDC's Clifton/Roybal Campus in Atlanta, Georgia. The agenda included updates from the Office of Minority Health and Health Equity (OMHHE), a review and discussion of recommendations from HDS to be presented to the ACD, and presentations and discussions with the directors of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and the Office for State, Tribal, Local and Territorial Support (OSTLTS).

Roll Call / Welcome and Overview of the Meeting

Lynne Richardson, MD, FACEP, Chair, HDS Subcommittee, called the CDC HDS to order at 9:20 am on Wednesday, April 16, 2014.

Ms. Gwen Baker, Program Specialist, OMHHE, CDC, called roll and established that a quorum of HDS Subcommittee members was present in person and via telephone. New and returning HDS Subcommittee members introduced themselves. A participant list is appended to this document as Attachment #1.

Updates from the Office of Minority Health and Health Equity

Leandris Liburd, MPH, PhD, Associate Director for Minority Health and Health Equity, CDC, and Designated Federal Official (DFO), HDS, welcomed the group and thanked them for their participation. She acknowledged that "the right people were at the table" to advance the cause of health equity within CDC and within the larger public health community, and indicated that an orientation session would be scheduled for the new subcommittee members.

OMHHE continues to grow and is focusing on the highest-priority activities. The office presented its first Quarterly Program Review in February 2014. All Centers, Institutes, and Offices (CIOs) at CDC undertake these forums with senior CDC leaders in which CIOs present their priorities and strategies for achieving them, and leaders offer feedback and guidance. OMHHE's review was well-received. They are following up on the response and will continue to advance their priorities.

The OMHHE priorities came from a strategic planning process, an executive summary of which will be shared with HDS. The reorganization of OMHHE was official at the end of December 2013. There are now three units within the office:

- Minority Health and Health Equity Unit
- Office of Women's Health
- Diversity and Inclusion Management Unit

In November 2013, OMHHE hosted a meeting on social determinants of health (SDH). OMHHE is CDC's lead office for the SDH topic area in Healthy People 2020. The November meeting invited leaders from within the US Department of Health and Human Services (HHS), CDC, and external partners to discuss moving forward on SDH. One of the outcomes of that meeting was a letter co-authored by Dr. Liburd and Dr. Judy Monroe, Director of OSTLTS and DFO of the



State, Tribal, Local and Territorial Workgroup (STLT) of ACD. That letter, sent to all 3000 health departments in the US, was a call to action promoting attention to SDH. There is a budding collaboration between HDS and STLT around SDH, as STLT feels strongly about reinforcing and supporting SDH work. There is momentum on these issues at the local level and within CDC. A copy of this letter will be shared with HDS.

OMHHE is proud of the CDC Undergraduate Public Health Scholars (CUPS) program. They are in the third year of the five-year cooperative agreement. In its first year, the program culminated with a week at CDC. Last year, the students visited CDC at the beginning of the program to tour the facilities and learn from scientists throughout the agency about what CDC does, how they came to public health, and how they maintain their passion for the work. This year, orientation will take place at CDC at the end of May and the program will continue through August.

Four institutions recruit and mentor the students: University of Michigan, Kennedy Krieger Institute (Johns Hopkins University), Columbia University, and Morehouse School of Medicine. In the past, nearly 3000 applications have been submitted for the program. CUPS can accommodate 200 participants, 10 of whom are graduate students in the Dr. James A. Ferguson Emerging Infectious Diseases Fellowship Program through the Kennedy Krieger Institute.

The next steps for CUPS include focusing on data collection and evaluation. It is important to document how many students from this program continue on to graduate school in public health, medical school, or another graduate program, and how many enter the public health workforce. CUPS committed to following students for two years after they complete the program, so that information should be available for collection soon. The follow-up will be more rigorous so that they can refine the program.

The Public health Leadership and Learning Undergraduate Student Success (PLLUSS) Program is for rising undergraduate sophomores or juniors who are minoring or majoring in public health. They complete course credits and participate in research and education on health disparities, urban health, professional development, and health promotion.

On Friday, April 18, 2014, the first *Morbidity and Mortality Weekly Report (MMWR)* focused on strategies for reducing health disparities will be released. It includes a foreword by CDC Director Dr. Tom Frieden, and five articles and five interventions:

- Reducing disparities in motor vehicle injuries among American Indians and Alaska Natives (AI/AN)
- Reducing smoking disparities among Vietnamese and Cambodians
- Reducing disparities in HIV and sexually transmitted diseases (STDs) among African American women
- Reducing disparities in HIV and STD among men who have sex with men (MSM)
- Reducing disparities in childhood vaccination coverage



The State of Health Equity at CDC Forum was held in October 2013. More than 220 CDC staff attended the forum on measurement. The outcomes of the forum will be reported in a manuscript that will be submitted to the peer-reviewed literature. The next forum will take place on November 12, 2014 with a focus on essential program elements: What has to occur in a public health program for us to say legitimately that it is addressing health disparities?

The CDC Forum series is comprised of four thematic areas, including: 1) Measurement; 2) Program; 3) Policy: What policies need to be promoted across the agency and in public health to promote equity?; and 4) Infrastructure: What infrastructure is needed to make sure health equity is integrated across CDC and its programs?

Dr. Liburd described the success of the current exhibit in the CDC Museum in the Visitor's Center titled "Health is a Human Right: Race & Place in America." Over 21,000 people have viewed the exhibit, curated by Louise Shaw, since it opened in late September 2013. OMHHE has hosted four outreach events with over 60 local organizations represented. These events brought in people from the community with whom CDC would not ordinarily interact. The events and special tours enabled CDC and OMHHE to make important connections and learn about other important work in Atlanta that complements the work highlighted in the exhibit.

The exhibit has been extended three times and will close on April 25, 2014. Its genesis was part of a centerpiece of OMHHE's 25th anniversary celebration, but the exhibit has achieved much more than originally planned. Not only is the work educational and moving, but also it "puts a face" on the work of health equity. The exhibit illustrates why the work in health equity is so important and why multi-sectorial and multidisciplinary approaches are critical, because health resides in so many arenas.

VOTE

Mr. Pestronk moved that the HDS recommend that OMHHE ask the CDC Foundation to consider options for sustaining the "Health is a Human Right: Race & Place in America" exhibit. Dr. Ro seconded the motion. The motion carried unanimously with no abstentions.

Discussion Points

Dr. Ross asked about possibly working with the Smithsonian. The former president of Spelman College is now the Director of the National Museum of African Art. Dr. Liburd pointed out that the CDC Museum is a satellite of the Smithsonian.

Dr. Botchwey noted that the ACD is touring the exhibit as part of their meeting. The tour would be a good time to share HDS's recommendation with them.

Dr. Ro recalled that HDS has discussed recruitment efforts for the CUPS program and asked about the diversity of the students who participate. Dr. Liburd answered that last year's group of students was very diverse, with a high percentage of African American, Hispanic, American Indian, and Asian students.



Ms. Wilson asked whether the program takes socioeconomic diversity into account as well as racial and ethnic diversity. Socioeconomic status may explain why some students do not continue to graduate school.

Dr. Liburd was not certain that socioeconomic status is an explicit criterion for the program. Some universities may incorporate that element. CDC's primary criteria include interest in public health and minority health issues.

Dr. Botchwey asked whether the program assesses students who do not pursue graduate school or the public health workforce to determine whether they incorporate public health knowledge and values into their non-public health work.

Dr. Liburd said that the question is important and can be incorporated into their data collection.

Dr. Ro congratulated OMHHE on the success of the program. Locally, she observed that the governmental public health workforce is aging out, and they are not seeing a pipeline of interested workers entering the field. CUPS is an excellent pipeline to public health schools and also presents opportunities to connect students to government public health.

Dr. Liburd agreed. Not all CUPS students come to CDC. The students recruited by Columbia University work in New York City. Much of their work is resource-driven, so many students work near their institutions. Assigning students locally puts them "on the ground" where public health impact occurs.

Dr. Ross said that the number of applicants to the CUPS program shows a high level of interest. The 2810 students who were not able to participate in the program, but who may have an interest in governmental public health, should be encouraged and directed to other opportunities.

Dr. Liburd said that the OMHHE website lists internship opportunities at CDC, and there are internships at other government agencies. They are not intentional about directing students who are not accepted into the program. Students often apply for multiple CDC internships.

Mr. Pestronk suggested that OSTLTS could be helpful in this regard, as they have programs with an undergraduate focus.

Dr. Liburd said that they are building a bridge between CUPS and the Public Health Associates Program (PHAP). PHAP assigns participants to local health departments, where they work for two years. Dr. Ro and Ms. Ryder will be strong resources as they grow in these areas.

Ms. Ryder was glad to hear about opportunities available at the undergraduate level and noted that there are also opportunities for training and development at the high school level. A series of internships through the Hispanic Centers of Excellence for high school juniors and seniors has been very successful and cost-effective. There are opportunities available through the National Health Service Corps. High school students may not be as well-prepared, but they are making pivotal decisions about their careers.



Dr. Ro noted that HDS has discussed the role of OMHHE in integrating equity across CDC. She asked about the new Diversity and Inclusion Management Program and how its work plays into the strategic planning process.

Dr. Liburd responded that the Diversity and Inclusion Management Program focuses on ensuring that CDC has a diverse and inclusive workforce and that the diversity of the workforce can be tied to improved health outcomes. The agency workforce should reflect the US population. The agenda crosses several arenas, from Human Resources (HR) to Equal Employment Opportunity (EEO); and OMHHE's role in training agency leaders, promoting cultural competency within the agency, and creating mentors who are "diversity competent" to create an environment within CDC that is welcoming of people, disciplines, and perspectives from a variety of different places. The Diversity and Inclusion Management work is part of the office's strategic plan. Their key goals are largely internal to CDC, including:

- ❑ Consistently conducting exit interviews to understand what drives employees to leave CDC and what management can address to retain a strong and diverse workforce.
- ❑ Ensuring that mentors are available across the agency who understand, accept, and embrace diversity, and who can help promote diversity across the agency.

Mr. Vargas said that the Health Equity Forums at CDC are exciting and asked how their content is developed.

Dr. Liburd answered that in 2011, a group of people from different areas in the agency held a series of meetings to determine how to distill a large focus area like health equity into concrete components which could serve as an evidence base and could be promoted across the agency.

Dr. Richardson added that originally, the HDS meeting was scheduled to coincide with the forum. The fall 2013 HDS meeting was not held due to the government shutdown, but they hope to align the schedules this year. The presence of HDS will add to the event's visibility within the agency.

Ms. Ryder asked what will happen to the "Health is a Human Right: Race & Place in America" exhibit when it is taken down. It is a powerful, diverse exhibit that should not disappear.

Dr. Liburd replied that OMHHE does not want the exhibit to go away. They are exploring different avenues to preserve it, such as photobooks or a digital archive. Copyright issues are presenting a barrier to some approaches, and the curator is considering how to proceed. There has been discussion about traveling the exhibit, but that will require extensive resources.

Dr. Richardson agreed and expressed hope that resources could be identified for the exhibit to travel. At the very least, a digital archive should be available. Dr. Liburd and Ms. Shaw are actively working on that task.

Mr. Pestronk wondered whether the CDC Foundation could assist by identifying businesses that might want to be identified with the exhibit that would find resources and assist with traveling.



Dr. Liburd said that they have spoken with the CDC Foundation about options regarding the exhibit.

Review of Recommendations to ACD

Dr. Richardson shared a series of HDS recommendations to the ACD. The recommendations came from deliberations by the HDS, as well as work toward developing a White Paper to consider minority health and health equity across CDC. An HDS workgroup, led by Dr. Ross, distilled the most important issues from the White Paper process into the recommendations.

Dr. Richardson presented draft versions of the recommendations for discussion and consideration during the April 2013 meeting of the ACD. The recommendations were well-received, and revisions have been made based on feedback received from the ACD. Dr. Richardson will present the recommendations to the ACD during their April 2014 meeting. There is not an opportunity to review or revise the recommendations further at this point, but if the ACD approves them, there will be opportunities to create additional language to use in the implementation phase or in communications.

These recommendations are the first agenda item from HDS to the ACD in some time. It is a good start, and they must think about what comes next and how HDS can have the most impact in moving disparity issues forward. They have unique positioning and opportunities to work through the ACD to elevate the visibility of health equity and diversity within CDC and to its grantees across the country. The recommendations follow:

- ❑ Recommendation #1: Develop a CDC framework for action to achieve health equity that includes:
 - Indicators, measures, and tools for monitoring trends in health equity
 - Evidence-based or promising approaches and essential program components to address health equity
 - Clarifying organizational structures within CDC that facilitate the integration of health equity into programs and research
 - Promotion of policies that support reducing health disparities and achieving health equity (e.g., as referenced in the National Prevention and Health Promotion Strategy)
 - CDC should develop a framework for action to achieve health equity that defines the scope of health equity and articulates how health equity can be integrated across CDC functions and programs to ensure that it becomes a true focus for the agency. The framework should include strategies to monitor the internal and external impact of the agency's health equity activities.

- ❑ Recommendation #2: Identify and monitor indicators of health equity. The *CDC Health Disparities and Inequalities Report (CHDIR)* is a seminal resource for the nation in monitoring health disparities and inequalities. Additional data sources should be developed to allow more complete reporting on disparities experienced by racial and ethnic minorities (including subpopulations), those with limited English proficiency, people with disabilities, sexual and gender minorities, people living in rural areas, and other socially disadvantaged population groups. CDC should report on these new indicators as new data become available.



- ❑ Recommendation #3: Align universal interventions that promote better public health, with more targeted, culturally tailored interventions in communities at highest risk to reduce health disparities and achieve health equity. Interventions designed to improve the health of all populations are not sufficient to reduce persistent, population-specific health disparities. CDC programs such as Million Hearts™, the President’s Teen Pregnancy Prevention Initiative, and the National Influenza Vaccination Disparities Partnership, which utilize both population-wide and targeted approaches, can serve as models for other CDC programs in reducing health disparities using both jurisdiction-wide approaches and targeted, community-based and clinical interventions. Every agency struggles with its responsibility to address health equity. The theory that “a rising tide lifts all boats,” or that good public health prevention and intervention helps everyone’s health improve, means that disparities could still exist. Specific interventions are needed to close the equity gap.

- ❑ Recommendation #4: Support the rigorous evaluation of both universal and targeted interventions and, where indicated, the use of culturally-appropriate evaluation strategies, to establish best practice approaches to reduce health disparities and achieve health equity. All programs and initiatives should devote resources for rigorous evaluation to determine the health equity impact.

- ❑ Recommendation #5: Build community capacity to implement, evaluate, and sustain programs and policies that promote health equity, especially in communities at highest risk:
 - Expand provision of technical assistance, toolkits, and other technical resources
 - Expand funding to support community capacity-building to reduce health disparities and achieve health equity
 - how to address the social determinants of health
 - how to improve health literacy
 - how to build cultural competence within the public health workforce
 - how to sustain health equity programs when federal funding ends

- ❑ Recommendation #6: Support training and professional development of the public health workforce to address health equity. Through its workforce programs and its work with public health agencies, CDC should play a leadership role in developing a public health workforce with the skills and competencies to effectively promote health equity among all groups at high risk for health disparities, as defined by race, ethnicity, socioeconomic status, geography, gender, age, disability status, and risk status related to sex and gender. CDC should continue to support pipeline programs and continuing education programs to ensure a diverse workforce prepared to address emerging public health issues including achieving health equity. Such public health issues should include multi-sectorial engagement as a requisite strategy to achieve health equity.

Discussion Points

Dr. Richardson explained that she will present these recommendations to the ACD and then take questions. She will move to approve the recommendations, someone will second it, and then the ACD will vote. There have been impressive impacts from recommendations presented



by other ACD subcommittees, as CDC has implemented them. The groups frequently report their progress to the ACD at subsequent meetings. The HDS recommendations reach broadly to every part of CDC. The first recommendation will require follow-up, with the next step focusing on how the framework will be developed and implemented.

Regarding the third bullet, Dr. Ro suggested that it would be helpful to clarify what is meant by “organizational structures and processes,” because the work is not just structural.

Dr. Richardson agreed and noted that the bullet takes a structural view because CDC has not evaluated the progress and success of its various health equity structures. Different CIOs at CDC have different models for how health equity is positioned organizationally. In some cases, a separate office or division focuses on health equity; in other cases, health equity is part of the center director’s staff portfolio; others take different approaches.

Dr. Ro added that different HHS agencies do the work differently as well. The health equity framework should be a foundational component of CDC’s strategic plan or overarching guiding document.

Mr. Fukuzawa asked whether a “framework for action” will also include a “framework for analysis.” Social analysis accompanies the question of why disparities exist.

Dr. Richardson said that a draft of the White Paper could be circulated to HDS members, however, she noted that there has not been momentum around the idea of moving the paper forward, particularly since it is dated.

Dr. Ross observed that the White Paper was drafted using the broader language of systemic reform, which is not time-limited. The broad ideas are as relevant now as they were four years ago. Dr. Botchwey said that the White Paper included a wealth of data and information.

Dr. Liburd explained that the language “framework for action” is important because “health equity,” is associated with an aspiration that is outside the purview of public health. Using the terminology of “action” lends itself to concrete, measurable levels, even if the scope is broad. The indicators, analyses, measures, and tools are opportunities for analyzing why inequities exist.

Regarding the third recommendation, Dr. Ro mentioned opportunities related to the Prevention and Public Health Fund (PPHF). The next transformation of the Community Prevention Grants (CTG) could incorporate health equity into how grantmaking is conducted. The principles are strong, but they may need to be worded clearly so that the work translates to the staff level.

Dr. Richardson said that this work will be part of the implementation plan if the recommendations are approved by ACD and accepted by the CDC Director. HDS may focus on facilitating various aspects of the implementation, such as possible changes in the Funding Opportunity Announcement (FOA) language. The recommendations are intentionally not “in your face” so that they will garner buy-in and will be implemented.



Dr. Ross noted that the nexus of recommendations 1 and 5 is the concept of incorporating “health in all policy.” That cohesive framework includes transportation, housing, joblessness, and other sectors. It is a well-documented and well-validated approach.

Dr. Richardson agreed and noted that HDS can help CDC move that idea forward, as it requires collaboration and cooperation across agencies across HHS.

Regarding Recommendation #6, Mr. Vargas observed that the language pertaining to health disparities is defined specifically, where other recommendations utilize more broad and inclusive definitions. He suggested that the presentation to the ACD could clarify that the recommendation applies to broad definitions of health disparities. Sexual orientation and other factors are not part of the list.

Dr. Liburd said that the terminology of “risk status related to sex and gender” was used in an early mission statement for OMHHE.

Dr. Horner-Johnson said that the recommendation was not meant to be exclusive, but it does list specific groups. The list might need to be more inclusive. Mr. Vargas said that the entire document is meant to be inclusive, but the language of the 6th recommendation is not as inclusive as it could be.

Dr. Richardson asked whether “sexual orientation and gender identity” was preferred. When creating the recommendation, they felt that it was important to list groups. Few individuals will likely identify themselves as belonging to the “risk status” group. Further, defining a group according to risk is not ideal. She said that she would mention these points in her presentation to the ACD so that it would be on the record.

Ms. Wilson asked about English proficiency. Mr. Fukuzawa asked whether immigration status should be included.

Dr. Richardson said that the recommendation refers to the workforce, which could be why immigration status and limited English proficiency were not included.

Ms. Wilson said that they should be aware of barriers for people with limited English proficiency and undocumented workers, and how those barriers might affect them.

Dr. Botchwey said that they hope to develop a public health workforce with skills and competencies that can work with these different groups. She suggested that Dr. Richardson’s ACD comments include limited English proficiency, immigration status, sexual orientation, and gender identity. She wondered about ways to align the HDS priorities with the recommendations to the ACD. It would be powerful to show consistency between their recommendations and the subcommittee’s work.

Dr. Duran asked how to improve the potential impact of these recommendations.



Dr. Richardson replied that feedback comes to ACD from the relevant parts of CDC on all of the recommendations that ACD approves. Some of the recommendations are specific to certain centers, such as the Center for Global Health (CGH) and OSTLTS. The HDS recommendations are the first that apply to the entirety of CDC rather than to a certain center or program. Leadership within CDC pays attention to the ACD's recommendations, and there is frequently discussion between the subcommittee and the relevant CDC group when recommendations are implemented. HDS can make itself available to work with center directors and other CDC leaders to the extent that it is possible to help implement the recommendations.

Mr. Pestronk offered suggestions via email regarding how the recommendations could be made more specific and therefore more easily tracked. When the recommendations are adopted, he hoped that OMHHE would revisit his comments to develop metrics for each of the recommendations. It would be helpful for OMHHE to have a tracking mechanism to know how the recommendations are utilized across the agency. He observed two elements of the CDC structure in its current organization. One is the operating divisions, which include the programs that are funded to carry out CDC's work. CDC's appropriations come to the agency this way. The other element of the organization, which is not well-funded, is offices and programs that connect across the agency. This work is important as programs need to work together toward larger agendas. At the same time, the work is difficult because many parts of CDC are not interested in being connected, and the funding mechanisms are not conducive to this approach. It is unlikely that OMHHE will have the resources it needs, so it will have to use language and tools to measure effect. The ACD needs to adopt the HDS recommendations to "move the needle" at CDC and institute these important processes.

Dr. Richardson concurred and noted that the metrics and indicators will be very important. She can ask ACD for a standing agenda item for each ACD meeting to report on progress on implementation of the recommendations. Mr. Pestronk added that HDS could request quarterly progress reports.

Ms. Ryder suggested offering the recommendations to be included in CDC's overall strategic plan. Part of that inclusion would be a request for CDC to develop a tactical plan for implementing the recommendations, as opposed to waiting to see whether the implementation occurs. It is appropriate for HDS to ask the agency for a response to the recommendations, including their feasibility and how they will be incorporated into the agendas and programs of existing centers.

Dr. Richardson indicated that she had not seen CDC's strategic plan, but she guessed that it includes language about health equity. A tactical plan for linking the program-level work is their main goal, as opposed to being incorporated into the strategic plan language.

Mr. Fukuzawa wondered whether instituting a small incentive for the centers to engage in health equity work would be beneficial. He noted the growing body of knowledge regarding climate change and its impacts on health disparities, which brings a special urgency to their work.



Review of Top Priorities from April 2013

Dr. Richardson directed the group's attention to the list of five top priorities from their priority-setting exercise from April 2013. She said she hoped to gauge the group's level of interest in pursuing them and to hear suggestions for additional topics to consider. All of the topics are important, but they cannot do them all if they want to do them well:

- 1) Funding Opportunity Announcement (FOA) language: Every FOA that CDC releases contains certain boilerplate language. The FOA process represents an opportunity to influence operational aspects of the organization by incorporating language pertaining to health equity into each announcement so that every applicant for CDC funds must address it. A new template was created recently. HDS can review that template in detail and make suggestions to modify the language. This time-limited work could have great impact.
- 2) Coordination of information across various organizations and advisory groups: HDS has interacted with an Institute of Medicine (IOM) Round Table. HDS could play a convening role in creating linkages across organizations such as IOM, the Office of Minority Health (OHM) at HHS, and other relevant groups throughout HHS and other federal agencies. HDS should develop a strategy for identifying important groups and to structure their communication. There may be opportunities to join the advisory committee for OMH and build a network of people who think about issues in diffuse ways.
- 3) Training and composition of the public health workforce: An HDS workgroup could be formed to address these issues, as it is likely to be an ongoing effort.
- 4) Prevention in Public Health Fund: The PPHF is a piece of the Patient Protection and Affordable Care Act (ACA). A substantial amount of CDC's funding is part of this fund. HDS can consider how the funds are utilized as well as priorities and vehicles associated with it. The PPHF mandates certain expenditures and was employed when the rest of CDC's budget was cut. HDS can help ensure that health equity is represented in the priorities.
- 5) Make response / recommendations regarding *CHDIR*: Rather than issuing a written report every few years, HDS suggested creating a "living" database that can incorporate new data as it becomes available. A "piece by piece" dissemination strategy may draw more attention than a large document. HDS can strategize how to maximize the report's impact as well as how to improve its format and structure.

Discussion Points

Regarding the first priority, Dr. Horner-Johnson noted that other efforts are ongoing related to adding disabilities to the FOA language. Coordinating with that work will strengthen the likelihood of seeing changes happen.



Mr. Vargas said that the focus on FOA language is important, but there is also a corollary process of training reviewers and the people who make funding decisions so that they can analyze applications that are meant to address certain populations.

Dr. Richardson agreed and suggested that the training work should be a separate task. There are tracking mechanisms to determine how much funding is awarded to programs that have a health equity focus or that incorporate culturally-tailored interventions. Providing assistance at the review level will be an important step.

Dr. Ro commented on the long history of conversations on these issues at the National Institutes of Health (NIH) and the National Institute on Minority Health and Health Disparities (NIMHD), particularly regarding reviews involving community-based participatory research (CBPR).

Ms. Wilson commented that all grant announcements from the Substance Abuse and Mental Health Services Administration (SAMHSA) for fiscal year (FY) 2013 include a required disparity impact statement to assure that the programs are actually serving the populations that they are funded to serve.

Julio Dicot-Taillepierre joined the meeting via teleconference and shared with HDS current efforts to incorporate health equity language into the FOA. OMHHE was involved in the redesigning of the FOA template in several ways. OMHHE is represented on the FOA Redesign Workgroup, which resides in a unit within the CDC Office of the Director (OD). The committee regularly evaluates the process by which CIOs write their FOAs and updates the guidance and template to ensure that they address operational issues and provide information for evaluation. OMHHE also participates in refining the guidance and template to ensure that the FOAs are outcome-oriented, plainly and clearly written, and are appropriately designed so that they are measurable. In this area, OMHHE provides input on key areas by which the template is organized. The areas that pertain to health equity include the Executive Summary and a subsection of the Approach section, which relates to targeting specific populations, the inclusion or populations and stakeholders in the effort, and program monitoring and evaluation, or how the approach will lead to specific, measurable outcomes. OMHHE participates in the review of new FOAs and are involved at the early stages of drafting the FOA to ensure that the announcement appropriately accounts for health equity concerns. The process begins approximately 12 months before an FOA is posted on www.grants.gov. OMHHE also provides input to draft FOAs and clears the final versions before they are posted. The guidance document for CIOs on how to write FOAs is in its second iteration. The first iteration addressed standard language to include health equity. Particular attention was paid to the target population and inclusion. Since then, evaluation data has been collected on the effectiveness of the guidance. In the third iteration of the document in October 2014, the language will be made more explicit and will provide examples in a resource packet.

Dr. Richardson said that HDS should review the template and the guidance document to provide suggestions for the current revision.



Mr. Dicient-Taillepierre encouraged HDS to consider both documents as a unit, as CIOs use both tools. The template includes language that cannot be removed and will appear in every FOA. Much of that language is dictated by federal regulations. The guidance document provides a more thoughtful approach to what is included in the template.

Dr. Liburd said that it will be helpful for HDS to understand the process that ensures adherence as well as the FOA clearance process. Additionally, details about the review process will help familiarize HDS with how these processes work at CDC and where the important levers are so that they can ensure that health equity is addressed in a robust way.

Mr. Dicient-Taillepierre will provide the guidance document, template, and the timeline for FOA review and clearance to HDS electronically.

Dr. Ross said that an infrastructure already exists via the Federal Interagency Health Equity Team (FIHET). Dr. Liburd said that OMHHE is represented at FIHET's monthly meetings. The directors of the OMH at Centers for Medicare and Medicaid Services (CMS), SAMHSA, and the Health Resources and Services Administration (HRSA) have monthly calls and share updates. HDS has not had a specific follow-up with IOM after the Round Table presentation. OMHHE is not participating in the IOM Round Table on population health. It will be important to keep issues of minority health and health equity prominent in that discussion. Many people and groups are working on health equity, and they come from different places. Coordinating these efforts is challenging, and they should be strategic about the linkages that they need to make to advance issues of health equity at CDC. Mr. Fukuzawa said that his staff is part of the population health Round Table.

Dr. Ro said that the directors of HHS OMH can take a leadership role to ensure coordination among agencies. They should not only consider coordination, but also alignment. The "CDC Framework for Action to Achieve Health Equity" should recognize where the health equity field is moving and incorporate community economic development, the built environment, climate change, and other issues. CDC can be a leader in health equity, but it is a government agency with a focus on the evidence base, so it can be difficult for CDC to move quickly. HDS can help ensure that the forefront of health equity influences CDC's actions. Their charge includes creating a voice for underserved populations and for reaching innovative partners.

Dr. Botchwey added that many potential partners are thinking about health. Partners need guidance relating to health equity, the evidence base, and outcomes measurement.

Dr. Richardson said that the strategy can consider the organizations, federal agencies, professional organizations, not-for-profit groups, and foundations that will be beneficial for linkage regarding health equity. There is language in the FOA about multi-sectorial partnerships, which reflects awareness of the issues. HDS can understand what already exists and can be built upon.



Mr. Pestronk suggested that the work could begin with an assessment to scan the landscape and learn about ongoing efforts. That information can be used to make connections and will be useful to many groups. Dr. Richardson said that HDS will not do that work, but the subcommittee can identify important and potentially fundable efforts.

Regarding the third priority, Dr. Ro noted that a great deal of work has been done on workforce development in health, albeit it not necessarily the public health workforce. It is important to generate actionable recommendations for CDC. She suggested that they apply a CDC-focused lens as they determine which of the priorities to take on and what might be doable.

Dr. Ross added that he is a member of the CDC Coordinated Council for Diversity in Public Health. They drafted a White Paper with specific, measurable, achievable, realistic, and time phased (SMART) objectives and recommendations. The council has met several times to address workforce diversity. It might be possible for members of HDS to participate in that group as well.

Dr. Ro wondered if there is a need for HDS to do more in this area, since so much work is going on and recommendations have already been generated. HDS should align with the Council and may be able to support its work.

Dr. Liburd agreed that a lot of work is ongoing pertaining diversity, but not everyone is satisfied with how diversity is being achieved. Actionable suggestions are welcome, especially as the council fleshes out its White Paper and makes recommendations for creating a more diverse workforce within CDC and in the broader contexts of public and medical health.

Mr. Fukuzawa asked about leverage points and mechanisms within CDC that can make an impact on workforce diversity.

Dr. Ross responded that other programs within CDC focus on public health workforce development. It is important to build on those successes and best practices to transfer those programmatic operations to other schools of public health. There is work to be done to build symbiotic relationships between CDC and schools of health and schools of medicine.

Dr. Liburd added that diversity includes a number of different programs and processes in multiple areas across CDC. For instance, HR is an important element of the work. CDC operates workforce development programs such as PHAP and the Epidemic Intelligence Service (EIS), and a number of different centers within the agency fund different fellowships. Some are administered by the Workforce Development Office, while some operate out of the national centers. The Pathways Program is an HHS-level program for all agencies. It is administered by HR, and OMHHE has its pipeline program.

Dr. Ross asked who drives the process. CDC is not in a position to drive all of the diversity work, but the agency can seek alignment.



Dr. Liburd pointed out that because CDC is a federal agency, they are subject to hiring policies and other requirements set by the Office of Personnel Management (OPM). There is concern with diversity at that level, so there is support for their work. A number of strategic plans for diversity start at OPM and come through HHS to CDC.

Dr. Richardson said that the priority includes not only workforce composition, but also training of the current workforce and incorporating cultural competencies into the current workforce. They must take care not to duplicate efforts and to focus on CDC and its pipeline programs pertaining to public health. The act of asking questions may move initiatives forward. HDS has heard about CUPS and would be interested in hearing about the diversity of EIS applicants and appointees, for instance.

Dr. Botchwey said that having a “big picture” of CDC will allow them to see the demographics of applicants to all of the various programs as well as the demographics of those who are admitted to the programs. HDS can encourage improvement in those numbers.

Dr. Richardson suggested that a workgroup could be formed to monitor the implementation of, and progress on, the HDS recommendations to ACD. The group could consider the rollout and communication of the recommendations, as well as progress on developing the framework for action.

Dr. Ross suggested that the workgroup could also map the HDS priorities to the recommendations so that their work is coordinated. Dr. Richardson said that the ACD recommendations are not the last set of the recommendations that the group will ever make, so they should not feel constrained by them. It might be worthwhile to find areas in which a recommendation has been made, but the group has not made the area a priority for itself. It is inevitable that there will be gaps, as the subcommittee cannot work on all issues simultaneously.

Dr. Mullen noted that since HDS is a subcommittee of the ACD, they should focus on that realm and find impetus for action on their recommendations. They may find success if they link with other ACD subcommittee. She advocated for linking to the work of the SDH Workgroup of the STLT Subcommittee to create a strong package for the ACD to consider. The SDH Workgroup was formed to reinforce the importance of SDH in addressing health equity.

Dr. Richardson explained that HDS would review the three recommendations developed by the SDH Workgroup of the STLT Subcommittee. STLT and HDS are currently the only subcommittees of the ACD. A number of ACD workgroups are in existence to address specific, time-limited priorities. There is a great deal of overlap between the SDH Workgroup recommendations and the HDS priorities and recommendations. The STLT Subcommittee has endorsed the HDS recommendations to the ACD.

Dr. Mullen serves on the SDH Workgroup of STLT and on HDS. The idea of forming a joint SDH Workgroup is open for discussion. Dr. Richardson agreed with the importance of alignment and noted that SDH is imbedded in several of the HDS recommendations. There may be additional opportunities to collaborate.



Mr. Fukuzawa referred to the second priority and noted the enormous role that evaluation will play in it and in the fourth priority regarding PPHF. He was not sure that any groups are systematically evaluating new data regarding the impact of climate change on vulnerable populations. These effects have been clear for some time, especially in heat-related situations. CDC can play a role at a national level, asking questions about equity. Further, with the emergence of “big data,” CDC can think about implications on health disparities.

Dr. Richardson was not aware of climate change on CDC’s “radar screen.” It is important to all populations. Big data is a specific focus of one of the ACD workgroups, on which she serves, which is working on public health and healthcare collaborations. A sub-group of that workgroup was formed to consider big data and the opportunity for public health data to inform healthcare providers as they move into population health, and leveraging healthcare administrative data to get more granular information on certain public health issues. She has raised health equity issues in those conversations.

Mr. Fukuzawa noted that climate change will force people, many of them poor people in low-lying areas, to move. Cities such as Miami will be affected, and the troubles of New Orleans are well-known. It is clear that there will be increases in disparities. Mr. Pestronk has participated in some of this work. A “futuring study of public health” has been commissioned to develop scenarios, and climate change is an important factor in them. Public health will need to address equity to mitigate the impacts of a changing world. When the report is released, he will share it with HDS.

Dr. Liburd pointed out that CDC is concerned about preparing vulnerable populations for evacuations or other events from an emergency preparedness perspective, whether the emergency is a natural disaster or related to something else.

Dr. Richardson added that those events may disproportionately affect vulnerable populations. This issue is important and HDS can revisit it when the report is available. A separate workgroup may not be needed if HDS can review the report and bring it to the attention of CDC.

Dr. Ro said that her state health department conducted a climate change survey of all of its local health jurisdictions (LHJs). The equity issue was not addressed in the survey. These concerns may also be in the STLT domain.

Dr. Botchwey added that the National Center for Environmental Health (NCEH) will be an important partner, especially in thinking about how the place-based structure can mediate health inequities that result from climate change. There may be opportunities for multi-sector partnerships to consider land-use regulations, zoning, and other strategies. It may be helpful to discuss climate change and health equity at one of the annual Minority Health Equity meetings.

There was discussion regarding community health needs assessments (CHNAs) and their impacts, as all nonprofit hospitals are required to do them. Dr. Richardson noted that CDC released guidance for hospitals regarding CHNAs. Public health can take the lead in these



assessments and provide hospitals with toolkits to ensure that the CHNAs are useful. They can look at the assessments from a health equity perspective.

Dr. Ro said that many toolkits are available for CHNAs from the National Association of County and City Health Officials (NACCHO) and other groups. At issue is not the assessments themselves, but getting community benefit into population health and the collective impact model. Ms. Wilson said that last April, a Round Table on the ACA and health equity discussed gaps in the CHNAs.

Dr. Richardson indicated that the ACD Public Health-Healthcare Collaboration Workgroup is considering how to leverage the community benefit piece of the CHNAs. There are opportunities to leverage hospital resources for community-level public health issues.

Dr. Ross reported that the Association of Academic Health Centers (AAHC) has worked on CHNAs and how to ensure that they have been implemented. Further, the group has discussed how to use the surveys and assessments to maximize community benefit.

Dr. Ro said that CDC can provide guidance and recommendations in these areas and help state and local health departments position themselves to have an impact. CDC also has an important role regarding data. There are many health equity and health disparity indices, but they are not easy to comprehend. CDC can provide a catalyst for accountability.

Ms. Ryder added that hospitals do not use the same evaluation mechanisms as public health and do not share data in the same way. CDC can carve out a role in this work as government agencies collaborate.

Discussion with Dr. Ursula Bauer

Dr. Ursula Bauer, Director, NCCDPHP, CDC, shared the center's work in health equity and health disparities. She emphasized that the work is challenging, and expressed her hope of receiving input from HDS regarding how to move forward in a coordinated and comprehensive way. This idea directly relates to the first recommendation from HDS to ACD regarding developing a CDC framework. Each center needs a framework that situates within an agency-wide framework. All of the work across the center's portfolio should have a common set of outcomes. NCCDPHP has engaged in work pertaining to the HDS recommendations 3, 4, and 5. The third recommendation about universal interventions is particularly important to the center, which reaches the entire population but also engages in targeted interventions that reach to specific populations where there are disparities.

This approach was formalized through the CTGs in 2011. The charge of the grants was to accomplish population-wide change in jurisdictions and to identify a specific population for a "deep dive." The grant outcomes were population change and change in the disparity. New funding opportunities across the board from NCCDPHP include that standard requirement. They hoped that the CTGs would allow for an evaluation of the approach to demonstrate that it is effective and efficient for achieving both goals: raising the outcomes for all populations and narrowing the disparity gap. The Communities Putting Prevention to Work (CPPW) initiative showed population-wide improvements, but also saw expansion of some disparities.



The CTGs were not funded for 2014, so the program will end after its third year. Funding is not available to complete the evaluation of the program. The center hopes to salvage some lessons learned, but it will be up to each of the grantees to close their individual programs and cull success stories. Because of the early end of CTG, there are limits to what can be learned. Nevertheless, new programming in the FY 2014 budget allows for more opportunities to continue with that approach.

NCCDPHP celebrated its 25th anniversary this year, and the center has always required that its grantees address health disparities. That approach has not been effective, partly because the center did not have the necessary tools, resources, and technical assistance to accomplish the requirement. The center has been building tools, including the *Practitioner's Guide to Advancing Health Equity*, to capture best practices and evidence-based practices and how they have been deployed in specific communities where health disparities are present. The guide's focus is on tobacco, nutrition, and physical activity, and it is meant to serve as a resource guide for the center's community grant portfolio. The center is continuing to develop other tools and resources so that as grantees are held accountable for these outcomes, they have access to resources and technical assistance.

NCCDPHP has established flagship programs for the purpose of reducing health disparities. The longstanding National Breast and Cervical Cancer Early Detection Program (NBCCEDP) targets low-income and uninsured/under-insured women. This program is the only one in which healthcare services are supported. A newer and smaller colorectal cancer screening program has been created based on the NBCCEDP model. A statute requires that 60% of the NBCCEDP funding is spent on direct services. The colorectal screening program does not have a statutory requirement, so it has a two-pronged approach. Approximately 30-35% of the funding is devoted to direct services to drill into the population of low-income and uninsured/under-insured people. Additional funding is focused on making a population-wide impact, so the program focuses on increasing screening rates for the population as a whole and narrowing the gap.

The center's second flagship program on health disparities is Racial and Ethnic Approaches to Community Health (REACH). This program began in 1999 and has utilized different approaches over its 15 years. Over time, REACH has moved upstream to address primary risk factors. The program has been on a budgetary "rollercoaster" for several years, as it has been zeroed out in the President's budget, so programs have begun to close out, but it is then re-funded by Congress and the programs ramp up again. REACH is again zeroed out in the President's proposed budget for FY 2015. The program saw a significant increase in FY 2014, and Dr. Bauer expected that Congress would continue to fund it at the \$50 million level.

A new funding opportunity for community prevention is available this year, and they hope to continue it for a five-year cooperative agreement. The program is community-based and focuses on a list of racial and ethnic populations, soliciting work in the community to address primary risk factors.



Numerous activities related to health equity and health disparities are taking place across NCCDPHP's divisions. The Office on Smoking and Health (OSH) houses the National Tobacco Control Program (NTCP) and a set of cooperative agreements that include national networks to address racial and ethnic populations. They hope to integrate this program with the new dual approach, charging grantees with population-wide impacts as well as narrowing the disparity gaps. New funding opportunities are also available in diabetes and heart disease prevention, and the dual approach to outcomes will be part of those programs. This year, the center has funding to support tribes.

Dr. Bauer concluded by noting that the center's approach to health equity and health disparities is not situated within a cohesive, overarching framework. They have been thinking about how to move the health equity agenda forward, but there is a great deal of work to be done to craft an overarching agenda. It will be challenging to bring the center's programs and funding under an umbrella to drive outcomes.

Discussion Points

Dr. Richardson thanked Dr. Bauer for her candor in acknowledging where the center is in terms of health equity, and where she hopes to be. She asked about evaluation and monitoring activities and how that evaluation is built around the dual approach to outcomes.

Dr. Bauer responded that the center is considering performance measures that are contained in the FOAs and cooperative agreements. They have benefited from the language in the standard FOA template. The template helps guide the program through the evaluation component of the funding opportunity and the performance measures and performance monitoring. They have heard criticism that they are "heavy on data collection," and they hope not to be burdensome to their grantees. At the same time, there is tremendous need for this information. They have learned that if they do not collect the data that they need, then they have to return to grantees to gather data for requests after the fact, which can be chaotic. Based on those experiences, they are working proactively to build data collection into the system to anticipate and prepare for requests. There are new opportunities to work with electronic health records (EHRs) and to work with health systems to ignite change in systems that will help address health disparities. While the center may not have the expertise to tap into those resources, they are charging themselves and their grantees to address them. The CTGs included a charge from Congress to contribute to the evidence base around community health. The grant program interpreted that charge as finding innovative strategies that work and also implementing evidence-based strategies in different settings and reaching different population groups. Demonstrating that programs do, or do not, work in other settings and populations; or that they work with modifications, is very valuable. The center's grantees are primarily state health departments, but are increasingly local health departments and non-governmental organizations (NGOs) that work in communities. The grantees indicate that they want to learn from each other. To that end, the center is working to create opportunities for grantees to share best practices, convening regional groups so that grantees can learn who is doing what and can tap into each other's expertise.



Dr. Ro commented on the experience of the REACH program, as well as with CPPW and CTG, which showed problems with sustainability. There were also problems with understanding the need for policy and systems change as well as for programs, especially when working with small, emerging populations. When REACH was cut, many of those tailored programs went away from the communities. Federal agencies can think more about sustainability. The programs, like philanthropic efforts, are not meant to be in place forever; however, the “stop-start” approach does not allow for a long view of sustainability. It affects not only the communities that are served by the programs, but also the people at the organizations who do the work, who do not have job security. It is difficult, then, for the organizations to grow and establish a track record. The ideas of sustainability and long-term impact on individuals and communities are not captured in evaluation. Rigorous evaluation is expensive if it is to be done well.

Dr. Bauer agreed that they have not solved the sustainability problem. CPPW was a two-year program with the goal of accomplishing policy, systems, and environmental change. The program had a “point in time” approach, investing heavily for a brief period to accomplish change that would lead to sustained impact over time. That kind of change was expected with the CTGs, but that program focused on how the activity that makes change in a community is sustained. CTG grantees were asked to have sustainability plans. The center is wrestling with the sustainability issue with its new FOAs. They do not want to support grantees to scour the universe for opportunities for additional grant funding, because that approach does not accomplish the goal. Their challenge is to create programs such that the program, and not just its effects, is sustained after five years. This issue is of concern for REACH, as there are a number of challenges to that program model, which is not scalable and sustainable. The only way to grow that program is to invest more dollars, but the funding stream is not growing over time. They are struggling to keep the funding stream that they have. REACH is strong, and individual programs have accomplished a great deal, but there is suffering when the funding goes away and the programs disappear. A model should grow the activity and keep it vibrant in the community without relying on continued CDC funding.

Mr. Fukuzawa said that the Prevention Institute has worked on ideas for resources to pay for healthier populations. He commented on the tragedy to have lost the opportunity to evaluate CTG, because it was such an important experiment in population health. There may be legal barriers to continuing, but he wondered whether individual CTG grantees have secured independent funding for evaluation. For instance, the California Endowment has invested in some of those sites.

Dr. Bauer said that they are trying to understand those opportunities now. The grantees, like the center, are focusing on how to close out their work in an orderly way. NCCDPHP is disappointed to lose the evaluation information, especially given what has already been invested in evaluation. At the end of year three, CTG was a \$450 million program. Mr. Pestronk observed that the CTGs were a casualty of conflict between two branches of the federal government. Some decision-making at the White House and HHS levels was problematic as well, and these decisions were beyond CDC’s control. It is important that the funding go to diverse enough communities so that where there are calls for appropriation, community advocacy is in place across the country. Regarding sustainability, he said that his



community was one of the early REACH grantees. Theirs was the only infant mortality-related project, and they have been able to sustain themselves in part because of relationships that formed within the community. Money is essential and can help generate those relationships on both sides, bringing attention to initiatives, but relationships and trust are the critical currency. People in the community must understand what they have to do to secure the quality of life that is their right, and that organizing will produce funds for programs and will lead to decisions that will make their communities healthier.

Dr. Bauer wondered how to inoculate the ideas of relationships and trust into FOAs and cooperative agreements.

Mr. Pestronk said that something happened in the last appropriation cycle that bumped REACH up, but eliminated CTGs. There are lessons to be learned in that shift, and one of the lessons is to find the important constituencies to support initiatives. Regarding CHNAs and community benefit, HHS and CDC initiatives can be directive. He hoped that the new forms of clinical care organizations that have different reimbursement methods may realize that health is a profit center: they can get paid to keep people healthy. Other departments in the federal government have programs that are analogs to CDC's, and integration across the government is important. Departments of Education, Transportation, Housing, and Justice all work in these areas, and a pool of people can recognize the connections between programs to take advantage of the funding that is available.

Dr. Bauer said that the FY14 budget brought significant changes to the center, with programs to shut down, new programs to build, and new money to spend—all at “lightning speed.” They try to think ahead to build relationships in key areas. Their relationship with CMS is stronger than it has ever been, and their relationships with HRSA and SAMHSA are growing as well. Outside HHS, they work with the US Department of Agriculture (USDA), but they struggle with the US Department of Education (ED), the US Department of Housing and Urban Development (HUD), and the US Department of Justice (DOJ) because it is difficult to figure out how to work together.

Mr. Pestronk said that people in communities face the same challenges. Communities have to commit time and resources to build those relationships, and if the funding is not available to support the work, then the work does not get done.

Dr. Ross said that even without formal evaluation, there may be important lessons to be learned from the CTGs, particularly pertaining to HDS's 5th recommendation to ACD on supporting the public health workforce in health equity. Communities across the capacity have not had the capacity to engage in alignment, yet those communities drive numbers and have wide disparities. Processes that work well focus on place-based funding. If they had identified “hot spots,” then they could possibly have expanded capacity and generated significant investment. The California Endowment and the Robert Wood Johnson (RWJ) Foundation support the idea of place-based funding.

Dr. Bauer agreed and added that the new tribal funding from NCCDPHP focuses on “hot spots” with severe health disparities and low capacity. These areas need high investments of



resources. The vision for CTGs was that they should address a number of issues. When the 2011 funding was received and the PPHF funds were available, the center carved a map of the US into a finite set of places. They expected to fund every one of those places as the CTG program grew over five years. The program also included capacity-building grants and implementation grants. When the capacity-builders met certain milestones, they were awarded additional funds to transition to implementation. Speaking about the REACH program, which has grown into a half-billion-dollar program over 15 years, she wondered what kind of program they would have created 15 years ago if they had known that it would last for at least 15 years and have that significant an investment, and what its outcomes would have been. That forward-thinking approach, plus stable funding, is critical to have significant accomplishments. Dr. Frieden pointed out that businesses plan and engage in research and development with that mindset. It is difficult for a government agency to think that way when it is not possible to predict the budget from year to year. As a center director and leader, she needs to think forward with large goals in mind so that she is prepared for ebbs and flows in the budget.

Mr. Fukuzawa applauded Dr. Bauer for “fighting the good fight.” They are all talking about the value of prevention, and they still have not won that debate. A more strategic mindset about the dollars that they all invest is needed. He hoped that Dr. Bauer and the center would not see the loss of CTG as a bitter defeat. It was an important experiment, and it is not over yet. The “residue” from CTG is a body of relationships, policy changes, and organizational and cultural changes. Sustainability should be viewed in that larger context. Prevention is not a discrete program for a specific population; it is about community health and changing mindsets.

Dr. Mullen asked how the center deals with political challenges that they cannot control and the degree to which they do or do not have discretion over their budget. Further, she asked about the disintegration of relationships as resources are more constrained and competition increases. She wondered about equity issues when funding is categorical as opposed to across shared risk factors.

Dr. Bauer said that the legacy of CPPW is that those communities will never do business the same way again. Health is on their minds when they engage in planning and economic development, transportation, and other processes. The culture has changed so that health is valued as a community good that brings other goods to the community. A similar effect may occur after the CTGs as well. Previously, she had observed among funders and partners was suspicion associated with integrating the portfolio. Their partners now realize that all of the chronic diseases are interrelated. A small number of risk factors drive many of the diseases. The strategies that combat the risk factors and diseases are similar across them. When resources come together and the integrity of the funding lines is maintained, they are able to be more efficient and effective in achieving outcomes. Part of that work includes building demand for an expectation of health. Health equity is the expectation that everyone has the opportunity to achieve optimal health and incorporates designing communities and organizing societies that allow and nurture that to happen. The work cannot be done when different diseases and risk factors are competing for their funds. They need their funds, but they also need to fight for the larger vision that delivers quality of life and health. Breaking down barriers between diseases and risk factors is helping advocates to see that they are fighting for something larger than their specific area of interest.



Dr. Richardson asked about workforce issues, both within NCCDPHP and their diversity and its training opportunities, and from the perspective of retraining the existing public health workforce both inside and outside CDC to be culturally competent to address the health of all populations.

Dr. Bauer replied that CDC has supported a minority fellowship program with the Directors of Health Promotion and Education. Five hundred fellows have participated in this one-year program aimed at encouraging graduates of minority-serving institutions into public health. A follow-up survey in 2013 indicated that 79% of the graduates of the program are still in public health, largely at the state and local levels. That program benefits NCCDPHP, but it is not a center-based program. As an agency, CDC has pushed CIOs regarding diversity and inclusion. She has taken different training courses and brought them to the center. The training frames diversity and inclusion as crucial for workforce productivity and strength. The principles of diversity and inclusion encourage people to work where they are most productive and help generate the best ideas. The principles are also relevant to CDC-funded programs and are representative of the population that CDC supported. A CIO-specific plan across the agency is being created for diversity and inclusion. The center participates in a number of agency initiatives, including a workforce initiative. They need to ramp up their activity.

Mr. Pestronk commented that the new community grant funding includes specific direction from Congress to ensure that the money is spent at the local level. That approach challenges the traditional ways that CDC does business, but it means that communities will have the resources to continue the work that needs to be done.

Dr. Richardson asked how HDS can be helpful as a center-level diversity plan is created, and whether there is interest in creating such a plan.

Dr. Bauer said that there is definite interest in creating a plan. The diversity and inclusion training sessions have been valuable to her, as those issues were not at the top of her mind when she came in as director. Pressure from above is helpful, because it is difficult for her to prioritize issues that she is not asked about. She praised all of the HDS recommendations and said she expected them to be embraced by the agency. She welcomed requests for information and any advice or guidance that HDS could provide.



HDS Priorities

Dr. Richardson led HDS in a discussion of the HDS priority areas and which members will commit to which areas.

Discussion Points

Dr. Horner-Johnson wondered whether the work on the first priority, the FOA language, might inform a recommendation pertaining to the fourth priority, the PPHF.

Dr. Richardson replied that the two are connected, but the mandates are a “moving target” every year. There is never assurance regarding what will be appropriated for what purpose. Their goal will be to develop a strategy and a long-range plan so that they can be nimble from year to year to respond to individual appropriations. She reminded the group of the five priorities, plus the sixth priority to follow up on the HDS recommendations to the ACD, including overseeing their rollout and implementation. The issue of the CHNA and community benefit is being addressed by the Public Health/Healthcare Collaboration Workgroup of the ACD.

The following HDS members volunteered to work on each priority:

- #1: Dr. Horner-Johnson, Mr. Vargas, Ms. Wilson
- #2: Ms. Ryder, Dr. Ross, Mr. Fukuzawa, Dr. Botchwey, Dr. Richardson
- #3: Dr. Ross, Mr. Vargas, Ms. Wilson, Dr. Ro
- #4: Ms. Ryder, Mr. Pestronk
- #5: Dr. Horner-Johnson, Mr. Fukuzawa, Dr. Richardson
- #6: Dr. Richardson

There was discussion regarding whether the sixth priority should be a workgroup or should be part of the work of HDS as a whole. A smaller workgroup may be needed to respond to requests for information, but it may be preferable for all of HDS to serve as a resource for advice and counsel to the CDC as the recommendations are implemented.

Dr. Richardson observed that HDS members had volunteered for each of the priorities, and she expressed her hope that they would not be over-extended.

Discussion with Dr. Judy Monroe on STLT Subcommittee

Dr. Judy Monroe, Director, OSTLTS, greeted the group and introduced herself. Among her roles is the DFO of the STLT Subcommittee of ACD, which began as a workgroup and recently became a subcommittee. The STLT Subcommittee is a 15-member advisory committee made up of health officials representing state, tribal, local, and territorial jurisdictions. The chair is Dr. David Fleming.

During their last in-person meeting, several STLT members pointed out that CDC should be taking on a more visible role regarding SDH, particularly concerning how to support health departments. SDH are critical to health, and the role of health departments in that work has been an important question. As a result of that discussion, STLT formed a smaller workgroup to consider this issue. The workgroup is chaired by John Auerbach.



Dr. Monroe and Dr. Liburd wrote a joint letter to health officials across the country to reinforce the importance of SDH, and conversations have been ongoing to establish what CDC can do internally to make a difference in this area, beginning with becoming more visible. The small group from the STLT Subcommittee generated a set of recommendations and presented them to the STLT Subcommittee at a teleconference meeting. The STLT Subcommittee supports HDS and their recommendations to the ACD, and the SDH Workgroup recommendations augment and support them without duplicating efforts. The SDH Workgroup of the STLT Subcommittee will develop additional recommendations regarding action steps that CDC might consider to support SDH-related work for STLT agencies.

Recommendation #1, to support HDS Recommendation #2: Identify and monitor indicators of health equity: CDC should explore the available non-health data sources from other domains (e.g., housing, transportation, public safety, income) that are readily available and that offer insights into the impact of the social determinants of health. CDC should also explore ways STLT agencies can collect and incorporate such data in their planning.

Recommendation #2, to support HDS Recommendation #6: Support training and professional development of the public health workforce to address health equity: CDC should develop a plan to either leverage existing informational and skill-building training opportunities for STLT agencies on how to incorporate SDH practices or develop new training opportunities where needed. Trainings might be directed at:

- Project officers
- New and mid-career public health workforce
- Public health leadership
- Non-traditional public health workforce (e.g., social workers, community workers)

The first recommendation is consistent with trends across the country. Dr. Monroe shared the observation of a member of the IOM Round Table on Population Health, who realized that her life's work on poverty and housing had really been about health.

The second recommendation ties in with STLT's previous work. OSTLTS was created to do cross-cutting work, and they cannot support health departments well unless they are also improving processes across CDC. Two important advancements bring opportunities to improve CDC processes:

The move to a standard template for all of CDC's FOAs came from work of the STLT Subcommittee, and the template has been a powerful tool for the agency. The FOA includes a checklist that is revised and improved every year. The checklist includes accreditation of public health departments, if appropriate.

Before OSTLTS was created, CDC had never had a consistent means for reaching all project officers across CDC. The agency is large, and it is easy for personnel to work in their "silos." Through recommendations from the STLT Subcommittee, OSTLTS has been able to make improvements and to reach all project officers consistently. There are certain things that every project officer needs to know, such as policies from the Procurement and Grants Office (PGO).



Health disparities are important across the agency, and there are areas where they can advance their work in health disparities and SDH, such as through leadership training.

The STLT Subcommittee will present the SDH Workgroup recommendations to ACD, and Dr. Monroe hoped for HDS's "blessing" of the recommendations. The recommendations are doable and can be implemented across CDC.

Discussion Points

Dr. Mullen said that in addition to being strong advice, the SDH Workgroup recommendations can represent alignment between the two subcommittees. They can also be helpful to CDC as the agency continues to work on population health and to collaborate with other partners within HHS to incorporate concepts of, and approaches to, health equity. These recommendations also strengthen ongoing work with CMS and the Center for Medicare and Medicaid Innovation (CMMI), encouraging thought about population health and not losing public health as the health system is transformed.

Dr. Botchwey commented on the first recommendation, noting its focus on non-health data and how it can inform health. She wondered whether the SDH Workgroup and STLT Subcommittee are interested in the opposite as well; that is, how health data can inform non-health sectors and can provide a central clearinghouse with that data. For instance, cities allocate Capital Improvement Project funds. Should those funds be allocated based on housing affordability and other planning-related measures, or should factors such as food deserts, physical activity, and walkability be taken into account as well? Cities should be able to find that data in a transparent system.

Dr. Monroe responded that OSTLTS has some funding for leadership training. They have been engaged in individual training for some time, but they recently recognized the need to shift to a multi-sector, team-based leadership training model. The name of the project is the National Leadership Academy for Public Health, and the Public Health Institute is their grantee. They are in the third year of that effort. The teams include representation from public health as well as city planning, education, transportation, and city government. The teams submit a project and work with a coach. This effort is consistent with CTG, and many CTG grantees have sent teams to this training, which takes a multi-sector approach to SDH. Regarding CMMI, she said that OSTLTS and others are involved with the State Innovation Model Awards and the Healthcare Innovation Awards. They are seeing more "upstream" thinking, particularly as hospitals begin to understand population health and the need to go farther than the physician in the emergency room.

Dr. Ross said that HDS has been discussing a lack of community capacity, particularly regarding information technology (IT). He asked about how to coordinate among departments and agencies to build infrastructure and capacity to collect and link data.

Dr. Monroe agreed that these issues are significant challenges, and are a lot to ask of health departments, many of which do not have capacity or resources available. Many of them rely on CDC to build IT infrastructure. Through the State Innovation Model Awards and the Healthcare



Innovation Awards, CDC has encouraged states to think about the larger population, and data exchanges are important elements of that work. Many plans submitted to CMMI include plans to build the IT infrastructure for that purpose. This work also leads to workforce development. The Number One workforce issue she hears from partners is a need for people who understand public health and who understand IT.

Regarding data, Dr. Ro said that there are pilots or innovations in public-private data collaborations. A great deal of data is privately owned and privately mined, and public health has not determined how to tap into that resource. Markets are able to attract people and change behaviors and environments more rapidly than public health. If public health does not have the resources to be at the forefront of IT, then they must forge partnerships that will allow them to take advantage of big data.

Dr. Richardson said that the Public Health/Healthcare Collaboration Workgroup of the ACD has considered the issue of bi-directional use of data and how to leverage substantial bodies of data available in administrative databases to have a more granular look at public health issues, as well as how to use public health data to help hospitals as they address population health and community benefit. She participates on that workgroup and will consider how to insert SDH and health equity into that conversation.

Dr. Monroe added that all of the cross-cutting offices at CDC need to be coordinated, and SDH is the “glue” that holds them together.

Dr. Botchwey has been working on a project that will create a neighborhood-level dashboard for quality of life and health in Atlanta, Georgia. That work has benefited from a good relationship with the Georgia Department of Public Health, which has a dataset that has been linked to obesity-related diseases. That work is powerful for the city’s planning department so that they can do cross-sector comparisons. The upcoming APA meeting, which includes urban planners from across the country, will have a keynote speech from the Surgeon General, and the signature presentations will focus on evidence-based decision-making using health data. CDC’s efforts could lead to nationwide neighborhood health rankings to capture where health really happens and could provide real tools to shape the environments in which we live. Further, there is a budding collaboration between CDC and the Georgia Institute of Technology focusing on IT.

Dr. Monroe added that the Georgia Tech relationship is exciting, particularly since that expertise does not reside at CDC, or in public health. Other work is ongoing with the Public Health Informatics Institute (PHII), as well as in other areas. It is important to coordinate their efforts to determine where the traction is.

Regarding the first recommendation from the SDH Workgroup, Mr. Pestronk suggested that it might be helpful to be explicit that CDC should explore ways for STLT agencies to collect and incorporate such data in their planning. Incorporating that data in their needs assessment will lead them to collect and incorporate such data in their policy development and into their local collective action efforts. The data collection is not just for their own purposes, but also to help with their engagement with other organizations and people who have similar goals. STLT



agencies should not work in an isolated fashion, but should collaborate with others. When the recommendations are presented to ACD, this background information can help illuminate why the recommendation is important.

Dr. Richardson noted that these recommendations would be presented to the ACD as written now, and had been approved by the SDH Workgroup of the STLT Subcommittee and by the STLT Subcommittee. The recommendations are a starting point to implementation, and the implementation phase will be the time to incorporate additional points. She encouraged HDS to think about where they intersect with the SDH Workgroup and how to operationalize their collaboration. They could simply keep communication lines open, or they could convene a joint working group to formulate a strategy.

VOTE

Dr. Ross moved that the HDS endorse the recommendations from the SDH Workgroup of the STLT Subcommittee. Dr. Horner-Johnson seconded the motion. The motion carried unanimously with no abstentions.

Dr. Richardson emphasized that approving the recommendations was the beginning of a larger conversation.

Regarding the second recommendation from the SDH Workgroup, Mr. Pestronk said that in order to work effectively with other organizations and groups that do not understand population health, it is important for the public health workforce themselves to understand population health. The workforce does not learn about population health in schools, but are “picking it up by osmosis, if at all.” They will not learn about it in training opportunities with other parts of the community because it is information that governmental public health personnel should bring to the community. When these perspectives are brought to the table, the “health in all policies” approach is more likely to be embraced by communities. Students may learn about population health in their Master’s programs, but the operationalization of these concepts is not likely to be taught. It is the purview of the governmental public health department to represent the entire population and ensure that the entire population, as well as sub-populations, that are not as healthy has the same opportunities. A small fraction of people who attend graduate programs in public health proceed to work in governmental public health departments.

Dr. Botchwey said that it will be helpful to think about how these recommendations feed into ongoing work by the Association of Schools of Public Health (ASPH) on “Framing the Future: The Second 100 Years of Education for Public Health.” There may be a survey to determine the benchmark on this issue, and there may have been thought toward how to address the issue.

Dr. Ross said that the group has developed core competencies, and one of them includes embracing SDH.



Mr. Pestronk wondered about an accreditation to determine whether, and how, this work is taking place. CDC can address the new group of public health personnel and help them understand what their role can be.

Dr. Botchwey noted that the second HDS recommendation, could also incorporate housing, transportation, public safety, and planning so that it echoes the SDH Workgroup recommendation.

Dr. Richardson expected that both sets of recommendations would be embraced by the ACD. Their next steps will be to move forward together to help implement them, both within the agency and with targeted outside groups. She asked about plans that the SDH Workgroup had discussed for their recommendations.

Dr. Monroe said that when small workgroups are created as part of the STLT Subcommittee, they sometimes create the recommendations and then are sunsetted. In this case, however, it would make sense for the workgroup to continue to work on making the recommendations more granular and on making them operational, perhaps even generating a second set of recommendations on that front.

Dr. Liburd noted that the work with the Healthy People 2020 SDH topic area may bring opportunities for additional linkages to the Office of Disease Prevention and Health Promotion (ODPHP) and those resources. They are building a portal on SDH for all STLT health departments. If they can have input into that process, then they can efficiently contribute to an immediately-useful product.

Dr. Ro recalled their conversations about the IOM and place-based strategies, which include looking at the intersections between race and class, race and place, disability and class, disability and place, and others. As they better understand those intersections, then they can flesh out their health disparity ideas further.

Dr. Richardson asked for input on how they can most usefully move forward.

Dr. Mullen felt that the idea of a joint workgroup would be welcomed. There will be a great deal of interest in the feedback from their discussions, and these issues are important to many people. The project should continue to move forward.

Mr. Vargas asked whether other CIOs might create their own recommendations for their own divisions, and how they might interact with them for implementation. The opportunity is ripe to work with OSTLTS, but they should consider how to work with other interested groups.

Dr. Richardson considered the work to be a collaboration with the STLT Subcommittee of the ACD as opposed to collaboration with an organizational aspect of CDC. They will think about how to create useful tools that will be adopted and disseminated across the agency and across STLT health departments. The conversation about those strategies is appropriate for a joint workgroup. The group might develop an additional set of recommendations for how that work needs to proceed and the most promising approaches. It is not possible to interact with all parts



of CDC, nor is it their role. Their role is to secure higher-level direction that can flow throughout the agency. Their next step after the ACD meeting will be for Drs. Monroe and Mullen to consult with the STLT Subcommittee to ascertain their interest in a joint group. If the idea is amenable to them, then they can schedule a conference call. She thanked Drs. Monroe and Mullen and stressed that she looked forward to their continuing work.

Public Comment

Dr. Richardson opened the floor for public comment at 3:19 pm. Hearing none, she proceeded with the meeting agenda.

Wrap-Up

Dr. Richardson reviewed the list of HDS priorities and HDS members committed to them. She asked who among HDS would like to be involved in a collaborative workgroup with the STLT Subcommittee on the SDH recommendations. Drs. Ro, Mullen, and Botchwey indicated their interest.

Dr. Richardson pointed out that HDS members indicated interest in six different areas and asked whether they can move all six efforts forward over the next six to nine months, or whether they should prioritize their efforts.

Dr. Ross noted that the FOA language work already has significant infrastructure and support.

Dr. Richardson agreed that the FOA work would move quickly and be timely.

Dr. Ross said that the PPHF is a longer-term effort with political entanglements, and it is not certain what the HDS can accomplish in one year.

Mr. Pestronk suggested that he have a call with Ms. Ryder and also consult with his staff. In those conversations, they can see whether there are specific elements within the topic that they can address, knowing that they cannot take on the entire issue. He will return to HDS with their conclusions.

Dr. Richardson agreed. She asked for HDS feedback regarding the joint working group on SDH. Their goal is to move forward with the HDS recommendations in a synergistic way. If the STLT Subcommittee is interested, then they should pursue a joint effort. She suggested that Dr. Mullen lead the effort, as she is already a member of both groups. Dr. Mullen agreed.

Regarding the FOA workgroup, Dr. Richardson said that much of their work will involve hearing presentations from staff and reporting. A call will be convened with Mr. Dicient-Taillepierre, and after they meet, they will be able to determine how best to proceed. Dr. Liburd will organize the call. She asked for leaders for each of the remaining priorities, acknowledging that Mr. Pestronk and Ms. Ryder will consult regarding their priority.

Dr. Ross agreed to lead the workgroup on priority #3, training and composition of the public health workforce.



Dr. Botchwey asked whether the second priority on coordination might align with the SDH joint effort.

Dr. Richardson replied that the group addressing coordination will focus on the SDH recommendations as well as the HDS recommendations and how to collaborate on an implementation strategy. The fifth priority on the *CHDIR* will contribute to this work as well. At some level, they all connect.

Dr. Botchwey agreed to lead the effort behind the second priority, coordinating information across various organizations and advisory groups. Dr. Richardson assured her that she would be brought “up to speed” on the traditional health partners.

Dr. Liburd said that she would secure invitations for Drs. Richardson and Botchwey to attend a meeting of the HHS Advisory Committee.

Dr. Richardson confirmed the final composition of the workgroups:

- Priority #1, FOA group: Mr. Vargas, Dr. Horner-Johnson, Ms. Wilson
- Priority #2, Coordination group: led by Dr. Botchwey, members are Mr. Fukuzawa, Dr. Ross, Ms. Ryder
- Priority #3, Workforce group: led by Dr. Ross, members are Mr. Vargas, Ms. Wilson, Dr. Ro
- Priority #4, PPHF: Mr. Pestronk and Ms. Ryder
- Priority #5, *CHDIR*: Dr. Richardson, Dr. Horner-Johnson, Mr. Fukuzawa
- Dr. Mullen will lead a joint SDH Workgroup / Recommendation and Implementation Workgroup with Dr. Botchwey, Dr. Ro, and Dr. Richardson.

Dr. Richardson indicated that they would plan for the next HDS meeting to coincide with the Health Equity Forum on October 7, 2014. She thanked the group for a productive meeting and looked forward to their next meeting.

The meeting was adjourned at 3:40 pm.



Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 16, 2014, meeting of the Health Disparities Subcommittee of the Advisory Committee to the Director, CDC are accurate and complete.

Date

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



Attachment #1: Meeting Attendance

HDS Members Present:

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

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

Fukuzawa, David, MDiv, MSA
Managing Director – Health
The Kresge Foundation

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

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

Pestronk, Robert M., MPH
Executive Director
National Association of County and City Health Officials

Richardson, Lynne D., MD, FACEP
Chair, Health Disparities Subcommittee
Professor of Emergency Medicine and of Health Evidence and Policy
Vice Chair for Academic, Research and Community Programs
Department of Emergency Medicine
Mount Sinai School of Medicine

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

Ross, Will, MD, MPH
Associate Dean for Diversity and Associate Professor of Medicine
Office of Diversity
Washington University School of Medicine



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

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

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

CDC Staff Present:

Baker, Gwen
Program Specialist
Office of Minority Health & Health Equity

Bauer, Ursula, PhD, MPH
Director
National Center for Chronic Disease Prevention and Health Promotion

Green, Yvonne
Director, Office of Women's Health
Office of Minority Health & Health Equity

Hall, Mary E.
Associate Director for Programs
Office of Minority Health and Health Equity

Monroe, Judy, MD
Director
Office of State, Tribal, Local and Territorial Support

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

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



Taillepierre, Julio Dient, MS
Public Health Analyst/Team Lead
Office of Minority Health & Health Equity

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

General Public Present:

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



Attachment #2: Acronyms Used in this Document

Acronym	Expansion
AAHC	Association of Academic Health Centers
ACA	(Patient Protection and) Affordable Care Act
ACD	Advisory Committee to the Director
AI/AN	American Indian/Alaska Native
APA	American Planning Association
APHA	American Public Health Association
ASPH	Association of Schools of Public Health
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health (CDC)
<i>CHDIR</i>	<i>CDC Health Disparities and Inequalities Report</i>
CHNA	Community Health Needs Assessment
CIO	Centers, Institutes, and Offices
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPPW	Communities Putting Prevention to Work
CTG	Community Transformation Grant
CUPS	CDC Undergraduate Public Health Scholars
DFO	Designated Federal Official
DHPE	Directors of Health Promotion and Education
DOJ	(United States) Department of Justice
ED	(United States) Department of Education
EEO	Equal Employment Office
EHR	Electronic Health Record
EIS	Epidemic Intelligence Service
FIHET	Federal Interagency Health Equity Team (FIHET)
FOA	Funding Opportunity Announcement
FOA	Funding Opportunity Announcement
FY	Fiscal Year
HDS	Health Disparities Subcommittee
HHS	(United States Department of) Health and Human Services
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRSA	Health Resources and Services Administration
HUD	(United States) Department of Housing and Urban Development
IOM	Institute of Medicine
IT	Information Technology
LHJ	Local Health Jurisdiction
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSM	Men who have Sex with Men
NACCHO	National Association of County and City Health Officials
NBCCEDP	National Breast and Cervical Cancer Early Detection Program



Acronym	Expansion
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NIMHD	National Institute on Minority Health and Health Disparities
OD	Office of the Director
ODPHP	Office of Disease Prevention and Health Promotion
OMH	Office of Minority Health
OMHHE	Office of Minority Health and Health Equity
OPM	Office of Personnel Management
OSTLTS	Office for State, Tribal, Local and Territorial Support
PGO	Procurement and Grants Office
PHAP	Public Health Associates Program
PHII	Public Health Informatics Institute
PLLUSS	Public health Leadership and Learning Undergraduate Student Success
PPHF	Prevention and Public Health Fund
REACH	Racial and Ethnic Approaches to Community Health
RWJ	Robert Wood Johnson (Foundation)
SAMHSA	Substance Abuse and Mental Health Services Administration
SDH	Social Determinants of Health
STD	sexually transmitted disease
STLT	State, Tribal, Local, and Territorial (Workgroup)
US	United States
USDA	United States Department of Agriculture

