



Minutes from the  
February 13, 2014

CDC Advisory Committee  
to the Director  
Health Disparities  
Subcommittee

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## **Advisory Committee to the Director Health Disparities Subcommittee: Record of the February 13, 2014 Meeting**

The Centers for Disease Control and Prevention (CDC) convened a meeting of the Health Disparities Subcommittee (HDS) of its Advisory Committee to the Director (ACD) on February 13, 2014. Participants attended via teleconference.

### **Introductions, Roll Call, and Welcome**

Dr. Lynne Richardson, ACD Chair and Designated Federal Officer (DFO), officially called the meeting of the CDC HDS of the ACD to order on Thursday, February 13, 2014. She welcomed everyone, noting that that it had been a long time since the HDS met, given that the last scheduled meeting was cancelled due to the federal government shutdown.

Ms. Gwen Baker called roll and established that a quorum of HDS members was present via teleconference.

### **Introduction of Health Disparities Subcommittee Members and Meeting Overview**

Dr. Richardson announced that since the last meeting, several new members joined the committee. She requested that everyone introduce themselves and offer some brief information about their affiliations and backgrounds (a list of participants and their affiliations is included at the end of this document). Dr. Richardson emphasized that the HDS is comprised of an extremely accomplished and diverse group individuals, and that she looked forward to working with each of them as they moved the HDS agenda forward.

As an overview, Dr. Richardson explained that the ACD meets twice a year and provides insight, suggestions, and policy advice to the CDC in a number of arenas. While the input from the HDS to the ACD and via the ACD to the agency has not been very robust over the last few years, she said she thought the HDS was now on a trajectory toward addressing that situation. The HDS has a role in helping CDC to stay engaged with and focused on disparities issues across the breadth of the work of CDC. Dr. Richardson's goal as Chair is for the HDS to be as strategic and engaged as possible in terms of helping to identify the various strategies by which this subcommittee can advance work on disparities and health equity within CDC and all of its branches.

To that end, Dr. Richardson reported that during the last HDS meeting, the members completed some work that had been ongoing before she became Chair in developing a set of recommendations that were presented to the ACD during its last meeting in April 2013. Like the HDS meeting, the last ACD meeting was cancelled due to the government shutdown. Nevertheless, the HDS received feedback from the ACD, which would be reviewed during this HDS meeting as preparation for presentation to the ACD meeting in April 2014, hopefully for final action.

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

Dr. Liburd welcomed all of the new members, stressing what a very exciting time it is to be part of the HDS, particularly due to its esteemed Chair, Dr. Richardson, who has been a phenomenal leader. In addition, the engagement of all of the members has energized the HDS, elevated it within the agency, and moved its purpose forward. Dr. Liburd looks forward to the leadership that will come from the new HDS members in collaboration with the existing members.



She then reported that near the end of December 2013, the Office of Minority Health and Health Equity (OMHHE) was reorganized and expanded. Not only will the OMHHE continue to have the lead responsibility for minority health and health equity, but also this office now includes CDC's Office of Women's Health and the Diversity and Inclusion Management Program. OMHHE is very excited about this reorganization. The mission of the Office of Women's Health is to provide leadership, advocacy, and support for the agency's research, policy, and prevention initiatives to promote and improve the health of women and girls. The mission of the Diversity and Inclusion Management Program is to provide and coordinate leadership for diversity issues CDC-wide; and ensure that CDC's diversity policies, procedures, and practices support employees in reaching their full potential so that they may better accomplish CDC's mission and be effective guardians of public health. OMHHE also views the addition of the Diversity and Inclusion Management Program as supportive of its work with the CDC Coordinating Council for Diversity in Public Health, which Dr. Will Ross Co-Chairs. OMHHE has been reinvigorating the work of that Council. OMHHE's strategic thinking regarding the intersections of these three units has raised some new and very important questions and opportunities to put before that Council. OMHHE has grown from about 16 staff members to approximately 25 staff members, and expects to continue to grow and become a robust focal point within the agency for women's health, diversity and inclusion, and minority health and health equity.

The CDC Undergraduate Public Health Scholars Program (CUPS), now in its third year, will run from May through August 2014. During the first week of the program, there will be an orientation at CDC. It is expected that approximately 190 undergraduate students and 10 graduate students can be accommodated. In the past, approximately 3000 students have applied to be part of this program. It is very competitive and highly selective. OMHHE views this as a wonderful opportunity to expose undergraduate students to public health practice and research, and to support them through the completion of their undergraduate programs. Ideally, the students in the CUPS program will go on to a school of public health or a school of medicine. The application deadline for this year was January 31, 2014. Dr. Liburd expressed her hope that students at the HDS members' universities were aware of this program and had an opportunity to apply. OMHHE continues to evaluate the program, which has a longitudinal cohort component in order to follow the students who participate to determine where they ultimately end up.

Dr. Liburd noted that within the next 4 to 6 weeks, she expected OMHHE to release the first *Morbidity and Mortality Weekly Report (MMWR) Supplement* that will be a CDC report on strategies to reduce health disparities. This document is considered to be a companion to the *CDC Health Disparities and Inequalities Report (CHDIR)*. The 2013 report was released in November and describes the burden of 29 health issues, including 10 social determinants of health that disproportionately impact communities of color and other groups. The first report on strategies to reduce health disparities was published in response to people asking what CDC is doing about these health disparities and what works, and was developed through a very rigorous process. The supplement will be comprised of five articles with a forward by Dr. Frieden, CDC's Director. The articles will address the following topics:

- Reducing disparities in motor vehicle (MV) injuries among American Indians/Alaska Natives (AI/AN)
- Reducing smoking disparities among Vietnamese and Cambodians



- Reducing disparities in human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs) among African American women
- Reducing disparities in HIV among men who have sex with men (MSM)
- Reducing disparities in childhood vaccination coverage

Interventions are currently being solicited for the next supplement, which is anticipated to be published. OMHHE expects to be able to generate high visibility and interest in these interventions and in future papers.

OMHHE has been celebrating its 25<sup>th</sup> anniversary with a number of key events, one of which was a *Social Determinants of Health Meeting* in CDC in November 2013. Dr. Howard Koh convened part of this meeting because of his leadership on Healthy People 2020. Also invited was Dr. Michael Marmot from the University College, London, who chaired the World Health Organization's (WHO) Commission on Social Determinants of Health (CSDH) and who has been a leader for these issues throughout the world. During a meeting with these individuals and key leaders from CDC, National Institutes of Health (NIH), and other CDC partners, Healthy People 2020 social determinants of health topic areas, for which OMHHE is co-lead, were discussed. OMHHE is one of the co-leads for that. This is the first time in its 40-year history of Healthy People that there has been a specific topic area related to the social determinants. About three years ago, Dr. Marmot was instrumental in the Department of Health and Human Services (HHS) deciding to include social determinants of health as a topic area. OMHHE also had a meeting with a representative from the Behavioral Risk Factor Surveillance System (BRFSS), for which a social determinants of health module is being developed, which will be very helpful in terms of the ability to monitor progress across the nation of social determinants. OMHHE continues to follow up on this, and expects to be able to leverage this to move work forward in terms of social determinants of health within CDC and with its partners.

Another centerpiece of OMHHE's 25<sup>th</sup> anniversary was a museum exhibit, with which earlier members of HDS are familiar. The exhibit, which opened at the end of September 2013, is titled "Health is a Human Right: Race and Place in America." It was expected to close in mid-January, but was extended to be open through February 2014. Due to additional requests that it be open longer, it was extended until April 25, 2014. Over 20,000 people have visited the exhibit. There have been 36 special tours and a number of outreach events have been planned. The exhibit brings attention to the evolution of minority health in the United States (US), and graphically and pictorially represents that health disparities are patterned, that exposure to risk and social conditions that contribute to social disparities are patterned and historical, and offers an opportunity to see what can be done to change those things. OMHHE is excited that the HDS members will be able to see the exhibit during the next meeting of the HDS on April 16, 2014.

## Discussion Points

Dr. Ro congratulated Dr. Liburd on making some headway and creating some visibility with respect to health equity and health disparities. In thinking about the next supplement regarding strategies to address health disparities and achieve health equity, she wondered whether consideration had been given to upstream factors pertaining to social determinants and setting forth a vision regarding how public health addresses some of the larger environmental factors. King County is evaluating the intersection of public health and community development, or the connection between public health and housing.



Dr. Liburd responded that OMHHE is examining such upstream factors, and she believes that the ability to have a focused agenda on social determinants through public health will require demonstrations that there are concrete, actionable efforts that can be made and that the intended impact is occurring. The 2013 *CHDIR* mentions 10 social determinants of health. One of these is communities situated close to major highways, which tend to be communities of color. There are various structural planning efforts in communities, such as health impact assessments, through which there is an opportunity to change these determinants. There are some challenges. It is important to identify who has been engaged in this work long enough to have evaluated it, and are ready to report that data are moving in the right direction. It is also important to be able to convince state and local health departments and other partners that this is work they can do consistent with the other tasks they are required to carry out. People often feel overwhelmed when they hear the term “social determinants of health,” and that they are being asked to do the jobs of education, transportation, et cetera. OMHHE’s leadership and charge is to make that more accessible, and to provide guidance in collaboration with people already engaged in this work to evaluate and report on this work.

Dr. Richardson congratulated Dr. Liburd on an excellent program that was presented at the *State of the CDC Health Equity Forum*, which she and Dr. Botchwey were able to attend. To many across CDC, the forum presented a clear vision of how they might incorporate some of the issues that were discussed. She applauded Dr. Liburd for keeping the momentum going within the agency, and keeping the focus on health disparities and health equity.

Dr. Liburd thanked Drs. Richardson and Botchwey for their attendance, which reflected a show of commitment and was not missed by people like Dr. Frieden. OMHHE is in the process of identifying a journal in which to publish the four papers consistent with the four components for the framework called for by HDS (e.g., components of measurement, essential program components, infrastructure needed, and policies). The fifth paper will address the overall framework that would synthesize the other four components into one. OMHHE is aware that it cannot ask the agency to do something that has not been clearly articulated or that is not scientifically sound. The *State of the CDC Health Equity Forum* is intended to do that. Though a date has not yet been set for the next forum, Dr. Liburd expressed her hope that HDS members would be able to attend.

Ms. Ryder said she had the privilege of a private tour of the exhibit last fall, and found it to be absolutely mind-boggling. Seeing things documented that she grew up with in terms of her public health experience was very meaningful to her. Her focus is primarily on migrant and seasonal farm workers. Excellent photographs were included in the exhibit that clearly document the history of the work that has been done by laborers of many different ethnic origins in this country. It was amazing. She appreciated Dr. Liburd’s comments about making the solutions to social determinants of health actionable. In terms of issues among the populations with whom she works, it seems like the only solution is to solve the problem of poverty. However, that is not very actionable. She looked forward to learning how to move beyond policy and publication to actual implementation at the frontline level. With the network of Community and Migrant Health Centers (CMHC) and the conferences that OMHHE supports, Ms. Ryder thinks there is an opportunity to communicate that directly to people who are at the frontline. The challenge is to communicate it as actionable steps such as making sure that the few laws that do exist to protect the population are followed, such as wage and hour laws or sanitation laws. This has to be translated to frontline, but practical applications where people who touch the lives of the population of concern on a daily basis can actually embrace these



and move forward will be a major challenge. There are corresponding advisory councils in different branches of HHS, each of which may have a comparable role that could be used as a channel for communication and policy decisions to advance the field.

Dr. Liburd agreed, pointing out the importance of identifying, with some precision, who needs to be brought to the table to move particular actions forward. Often when these issues are discussed, they are conceptual and at a 30,000 foot level. The Forum is one place to identify who needs to be engaged.

Dr. Botchwey noted that many of the HDS members had not seen the exhibit, and suggested that a tour be arranged during the April 2014 meeting. She suggested that the perhaps a recommendation could be made by OMHHE or HDS for the ACD members to tour the exhibit during their meeting as well. Dr. Liburd responded that there is a plan to incorporate a tour into the April 2014 HDS meeting, given that the exhibit has been extended.

### **Review Recommendations to the Advisory Committee to the Director**

Dr. Richardson explained that work on the recommendations to the ACD began in 2012 in an effort to solidify the vision of HDS for how health disparities and health equity work could be moved forward within CDC. That culminated in a work group, who reported during the April 2013 HDS meeting. The details of this report can be found in the minutes of that meeting. Following a detailed and spirited discussion, several revisions were made and Dr. Richardson presented a set of recommendations to the ACD during its April 2013 meeting, at which time there was further discussion. This is the usual process of the ACD. Something is presented during a meeting, it is discussed, feedback is offered, the subcommittee that originated the item makes revisions based on the feedback, and then re-presents during the next ACD meeting. The revisions were ready in time for the October 2013 meeting; however, that meeting was cancelled. Therefore, the revised recommendations will be presented to ACD during the April 2013 meeting. A final version of the recommendations that incorporated the feedback from the April 2013 ACD meeting was submitted to HDS members via email before this teleconference.

Acknowledging that this was novel information to the new HDS members, Dr. Richardson noted that there was still an opportunity to perfect wording and suggestions about how the recommendations could be presented to the ACD. She said did not want to reopen the entire discussion of the recommendations since they were close to being adopted by the ACD. The experience has been that once the ACD approves recommendations, the CDC Director acts on the recommendations to implement them throughout the agency. This represented an opportunity for HDS to try to infuse a new set of actions across the agency with regard to health equity. Dr. Liburd added that once the recommendations are accepted by the ACD, they will be sent forward to Dr. Frieden for action. Dr. Frieden can prioritize the recommendations and state that they are recommendations for advancing health equity across the agency, and encourage other centers to rally around these recommendations and work closely with OMHHE to integrate them into programs. There needs to be some statement of validation from Dr. Frieden to the centers, institutes, and offices (CIOs). OMHHE already has efforts underway that are consistent with the recommendations, but to have them validated by Dr. Frieden and shared with the CIO leadership reflects an indication that OMHHE wants to work more closely with them. Dr. Richardson then reviewed the recommendations, with HDS discussion points and suggestions following each one.

### **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)

*HDS Discussion Points/Suggestions*

- This is not the language that came from the subcommittee. Dr. Liburd translated into CDC language. For example, “framework for action” is the rubric used within the agency to frame major initiatives.
- There was some push-back about the focus on evidence-based approaches in this recommendation. Sometimes there are innovations for which there is not yet clear evidence, but which are promising and that those should be supported and promoted. Therefore, the term “evidence-based approaches” was revised to “evidence-based or promising” to be more inclusive.
- In all of the other recommendations include a paragraph that is more explicit than in Recommendation 1, because it is really about integrating and adopting health equity as part of all the work that CDC does. It could be more explicit in terms of the intent of this recommendation being the integration of health equity into the work of CDC itself, versus the concepts that this is being pushed out to state and local jurisdictions or communities. This is really about what occurs internally at CDC. A brief paragraph stating this would help to ensure that this is not misinterpreted.
- This recommendation will secondarily impact the work of state and local health departments through the funding opportunity announcements (FOA) issued by CDC.
- The two cannot be totally separated. There will be some reinforcement and additional support for this recommendation through another subcommittee, the State, Tribal, Local, and Territorial (STLT) subcommittee of the Office for State, Tribal, Local and Territorial Support (OSTLTS), which is extremely interested in how CDC will support those levels of public health in addressing the social determinants. A lot of the interest in that relates to health equity and health disparity. Implementation has to occur with CDC and at all of those other levels of government.
- That needs to be better codified. Everyone agrees that it is not “either/or” but the last bullet regarding promotion of policies references the National Prevention and Health Promotion Strategy, but it should also indicate that it requires integration of this language in the FOAs issued by CDC. This will help set the tone that this is an internal as well as an external recommendation.



- A short paragraph could be included following the recommendation to make that very specific so that it is not misinterpreted. Some language will be crafted and submitted to members for review before the ACD meeting. HDS will be meeting before ACD, but whatever will go on the ACD agenda will probably need to be finalized fairly soon. HDS is expected to be on the agenda, and there is a very short window of time to revise and submit the recommendations to go in the ACD packets.
- Because this is going to a group that may not be familiar with the term “health equity” and because there is some confusion with regard to several terms that can get confused with “health equity,” an accompanying page should be included that has definitions and explanations of relationships between different terms such as “equity and disparity,” health equity and health disparity,” and “social determinants.”
- There was a much longer document, which included those types of definitions and talked more conceptually and theoretically about the etiologies of disparities and health disparities. Some of that could be distilled into a one-page document. There have been a lot of fairly well circulated policies, platforms, and programs. Perhaps some of the language of those could be listed in a one-page document. The ACD is familiar with these terms, but there could be some value in an accompanying document for dissemination throughout the agency as the recommendations get moved forward.
- Perhaps there should be an accountability component to Bullet 3 regarding clarifying organizational structures within CDC.
- A new FOA template was implemented in 2013 that includes health equity language. OMHHE is in the process of further defining the guidance of what that means. This is how the framework and State of Health Equity at CDC fit together, because it is important for people within the agency to be clear about the parameters they need to address to be able to legitimately say that health equity is incorporated into their FOAs, and that there are very clear indicators about the program elements. A work group is working on the essential program elements, which will become part of the guidance on health equity within FOAs. The template for FOAs includes the word “health equity.”
- It is better not to take anything for granted. Perhaps language concerning FOAs should be more explicitly included in the recommendation under the fourth bullet.
- Concern was expressed that this may be moving away from CDC promoting equity outward, which is captured in some of the other recommendations, toward also making sure that equity is embraced and integrated throughout CDC. If an example is going to be included about how CDC promotes equity outward, consideration should be given to the example internally. For instance, when budgets are created or programs are designed, is the equity impact being considered?
- Perhaps that could be included in the paragraph that follows the bullets in Recommendation 1. This is a place to make clear that this refers to both internal CDC programs and FOA language.
- Bullet 3 refers to the way that health equity is structurally organized within one of CDC’s centers, and is specifically aimed at the entire structure of CDC. The intent was to assess



the experience of the various agency structures pertaining to health equity and which ones work better and should be standardized as best practices. For example, some centers within CDC have offices of health equity and some do not, although they do address health equity in other ways.

- Recommendation 5 may address how CDC uses its resources. It is about community capacity, and one way that occurs is through FOAs and other funding mechanisms.

### **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 indicators as new data become available.

#### HDS Discussion Points/Suggestions

- No additional comments were offered for Recommendation 2.

### **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 the Community Transformation Grants is a model for other CDC programs to use to reduce health disparities using both jurisdiction-wide approaches and targeted, community-based and clinical interventions.

#### HDS Discussion Points/Suggestions

- If the upcoming *MMWR* on disparities will include discussion about targeted culturally tailored interventions and communities at risk, this will be a great.
- The description of childhood immunization program component of the upcoming *MMWR* is considered to be universal, given that all 50 states, territories, and jurisdictions in the US are funded to insure that children are immunized. This is supported with other types of policies within states that require children to be immunized to attend school, et cetera. The HIV and STD interventions that target African American women would be considered more targeted. Another HIV intervention targets African American MSM. The point of those that makes them targeted is that they are much more sensitive to the cultural, social, environmental, and economic nuances that these communities experience; whereas, HIV interventions that are focused on the broader population of people who are at risk might miss these individuals.
- I would be a good idea to reference something from the strategies report in Recommendation 3, which will hopefully be released before the April 2014 meeting.
- Given that the fiscal year 2014 budget no longer contains Community Transformation Grants (CTG), they should not be included by name. However, the concept can be referenced. Language such as “community-based health promotion programs” or “community-based public health programs” could be used instead. CDC has sponsored several community-based programs, such as Communities Putting Prevention to Work (CPPW) and Racial and Ethnic Approaches to Community Health (REACH).

#### **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.

#### HDS Discussion Points/Suggestions

- Critical for this recommendation is providing financial support within existing grant structures to evaluate these programs. Everyone wants evaluation to be done, but no one wants to pay for it. Specific funding should be provided not only by CDC, but also all other federal agencies to conduct rigorous evaluations. Otherwise, it will not be done.
- It is important to note that the rapidly shrinking budget is estimated to be on the order of approximately 20%. Some of CDC’s budget is earmarked for initiatives that no one can alter. These comments are heard regularly during ACD meetings, and it remains unclear what more can be said than what is being articulated with these recommendations.



- There are places within CDC's budget, particularly in areas related to chronic disease and the REACH program where there are more resources. In those places where there are, this recommendation could speak to using some of those additional resources not only to expand existing programs, but also to include funding for rigorous evaluation. It is that evidence, if it proves to be true, that everyone believes will drive further funding because the value and return on investment will be clear.

### **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

### **HDS Discussion Points/Suggestions**

- No additional comments were offered for Recommendation 2.

### **Recommendation 6**

Support training and professional development of the public health workforce to address health equity.

CDC, through its workforce programs and its work with public health agencies, should play a leadership role in developing a public health workforce with the skills and competencies to effectively promote health equity. 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.

### **HDS Discussion Points/Suggestions**

- Perhaps it would be worth spelling out; workforce and cultural competency issues. There is sometimes a tendency to assume that this refers specifically to race and ethnicity, while issues such as disability, sexual orientation, gender identity, and rural versus urban status are left out. Perhaps some of these other issues should specifically be called out.
- It was suggested that the first sentence in the second paragraph could be rephrased to read: "CDC, through its workforce programs and its work with public health agencies, should play a leadership role in developing a public health workforce with the skills and competencies to effectively promote health equity among all groups, including: and then name all populations of interest.



- ❑ If the first sentence says a “diverse public health workforce” it is up to CDC to define “diversity.” That could be done in the one-page sheet mentioned earlier. The last sentence in the second paragraph is pretty straightforward, so changing the first sentence in the second paragraph may make the recommendation too verbose.
- ❑ The recommendation is about improving the diversity of the public health workforce, and training the entire public health workforce to provide culturally competent programs and services.
- ❑ There is always tension between explicitly stating things versus making something so long that people lose interest and do not read it.
- ❑ Some members maintained that more should be said about diversity in the paragraph. When thinking about social determinants of health, it is important for the workforce to understand the languages of planning, transportation, housing, and other fields that have direct impact on the outcomes of a population of concern. The *National Prevention Strategy* refers to a “diverse multi-sectoral public health workforce.” CDC has paid a lot of attention to this.
- ❑ This document has been significantly shortened from its original length, but calling out diversity by race/ethnicity, sexual orientation, social class is critical in that people do need reminders because otherwise, people too quickly fall to a what diversity is and is not. It is important to talk about the growing importance of the public health workforce having the skills and competencies to work with other sectors.

### Overview of Priority-Setting Exercise from April 2013 Meeting and Next Steps

Dr. Richardson reported that during the last HDS meeting, time was spent trying to develop some priorities for the work that this subcommittee will engage in over the coming year or two. There was a brainstorming session during which everyone was permitted to suggest anything they thought would be useful for HDS to do, along with a priority-setting exercise recognizing that the subcommittee could not possibly accomplish all of the suggestions raised. They were able to combine some suggestions and streamline them down into five areas of focus. Some preliminary timetables were made for each of these areas, all of which were derailed by the government shutdown. Dr. Richardson reviewed the five areas and requested that members consider how to organize into work groups to pursue these activities, what format should be utilized, and to which committee or committees they would like to commit. The five areas are as follows:



1. FOA language:
  - Request the language for the new template, and review for health equity language
  - A recent ASTHO article has some specific guidance that is relevant to the FOA
  - Review Seattle-King County's FOA, which addresses policies pertaining to health equity
  - Send comments/feedback on language to OMHHE; this requires more thinking
  - Review information via presentation
  - These funds should be tracked to understand the impact of funds that are actually spent on programs with a health equity focus; metrics are needed to ensure that this happens and HDS would like to have active input into identification of the metrics
  - It is important to assess not only what was initially funded, but also what actually gets done
  - This priority could be addressed on conference call #1
  - No work group is required
2. Coordination of information across various organizations and advisory groups:
  - Contact the IOM point person, chairperson(s) and other groups to discuss the commonalities of everyone's missions and potential opportunities
  - Several suggestions were made (HHS Office of Minority Health Advisory Committee, IOM's Roundtable on Population Health, others)
  - Strategy + call
3. Training and composition of the public health workforce:
  - Address diversity of the workforce
  - Address cultural competence
  - Coordinate with the CDC Coordinated Council for Diversity in Public Health
  - Should develop a work group for this
  - Presentation on conference call #3
4. Prevention in Public Health Fund:
  - Make a recommendation about the criteria and framework and how funds are used
  - This would need to be a workgroup; staff would have to be hands-off
  - While HDS might not be able to direct CDC in how to allocate PPHP funds, there is a way to shape the opportunities that come out of these funds through the FOA language
  - Part of these funds are supposed to be for workforce development
  - Evaluation / HRSA / Community Voice
5. Make response/recommendations regarding *CHDIR*:
  - Ask Paula and Rachel about the best structure
  - Review report and electronic copy of presentation
  - Offer comment and feedback, understanding that it is probably too late to make recommendations for the content of the 2013 iteration, but input can be offered with regard to dissemination strategies
  - Conference call #2 for guidance on dissemination, deciding on future action, and discussing the previous white paper



## Discussion Points

Dr. Ross indicated that with regard to Item 2, the HDS was contacted by the Institute of Medicine (IOM) Roundtable. Many of the recommendations being presented emanated from that discussion. OMHHE needs to follow-up with the IOM Roundtable co-chairs to determine how their priorities intersect with HDS's priorities.

Dr. Richardson thought they were seeking some type of continued venue to coordinate information across the various groups. It was not clear at this point what the proper vehicle for that might be. They will probably need to have a couple of representatives from HDS pursue that, whether it is through cross-fertilization between committees or a regular forum that brings people together. She agreed that they need to circle back to the IOM Roundtable group, which is a "jump off" point for who else HDS needs to speak with regularly across HHS and other federal agencies in order to leverage its efforts through coordination.

Dr. Fukuzawa inquired as to when the HDS members needed to indicate their decisions on the work groups.

Dr. Richardson indicated that an email would be sent to the HDS members requesting that each member indicate a first and second choice to see where they stand with interest in each work group or effort. Prioritization must also be done, given that some topics are more time-sensitive than others. Work groups generally involve two or three teleconferences, with work in between, before something actionable is submitted to the full HDS.

## Public Comment Period

The following public comment was submitted to Dr. Liburd via email:

Dr. Liburd,

Good morning. I hope all is well.

I am on the Advisory Committee to the CDC Director, Subcommittee on Health Disparities. An undergraduate fellowship program was mentioned, and it was also mentioned that there are 10 slots for graduate students. Is there a place where I can find more information on this particular program to share with the members of the Association of Minority Health Professions Schools (AMHPS)? AMHPS is the group of HBCUs which award doctoral degrees in medicine, dentistry, pharmacy, and veterinary medicine. Thank you.

Lodriguez Murray  
Senior Vice President  
Health & Medicine Counsel of Washington



## **Wrap Up / Adjournment**

With no further business posed or questions raised, Dr. Richardson officially adjourned the February 2014 HDS meeting.



## Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the February 13, 2014, meeting of the Health Disparities Subcommittee of the Advisory Committee to the Director, CDC are accurate and complete.

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Date

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



## Attachment #1: Meeting Attendance

### HDS Members Present:

**Nisha D. Botchwey,, PhD, MPH, MCRP**

Associate Professor  
School of City and Regional Planning  
Georgia Institute of Technology, College of Architecture

**David Dwight Fukuzawa, MDiv, MSA**

Program Director-Health  
The Kresge Foundation

**Willi Horner-Johnson, PhD**

Research Assistant Professor  
Institute on Development and Disability  
Department of Public Health and Preventive Medicine  
Oregon Health & Science University

**Jewel M. Mullen, MD, MPH, MA**

Commissioner and State Health Officer  
Connecticut Department of Public Health

**Robert M. Pestronk, MPH**

Executive Director  
National Association of County and City Health Officials (NACCHO)

**Lynne D. Richardson, 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

**Marguerite Ro, DrPH**

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

**Will Ross, MD, MPH**

Associate Dean for Diversity and Associate Professor of Medicine  
Office of Diversity  
Washington University School of Medicine



**E. Roberta (Bobbi) Ryder**

President/Chief Executive Officer  
National Center for Farmworker Health

**Hector Vargas, JD**

Executive Director, Gay and Lesbian Medical Association  
Health Professionals Advancing LGBT Equality

**Cheri C. Wilson, MA, MHS, CPHQ**

Faculty Research Associate  
Health and Policy Management Department, Hopkins Center for Health Disparities Solutions  
John Hopkins Bloomberg School of Public Health

**CDC Staff Present:**

**Demetria Gardner**

Committee Management Specialist  
Management Analysis and Services Office

**Gwen Baker**

Program Specialist  
Office of Minority Health and Health Equity

**Mary E. Hall**

Public Health Analyst  
Office of Minority Health and Health Equity

**Gayle J. Hickman**

Committee Management Specialist, ACD  
Advance Team, Office of the Chief of Staff

**Leandris Liburd, MPH, PhD**

Director  
Office of Minority Health and Health Equity (OMHHE)

**Judy Lipshutz**

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



**General Public Present:**

**Anne C. Beal, M.D.**

Deputy Executive Director and Chief Officer for Engagement  
Patient-Centered Outcomes Research Institute (PCORI)

**Lodriguez Murray**

Senior Vice President  
Health & Medicine Counsel of Washington

**Stephanie Wallace**

Medical & Scientific Writer/Editor  
Environmental Scientist  
Cambridge Communications & Training Institute



## Attachment #2: Acronyms Used in this Document

Acronym	Expansion
<b>ACD</b>	Advisory Committee to the Director
<b>AI/AN</b>	American Indians/Alaska Natives
<b>BRFSS</b>	Behavioral Risk Factor Surveillance System
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHDIR</b>	<i>CDC Health Disparities and Inequalities Report</i>
<b>CIOs</b>	Centers, Institutes, and Offices
<b>CPPW</b>	Communities Putting Prevention to Work
<b>CSDH</b>	Commission on Social Determinants of Health
<b>CTG</b>	Community Transformation Grants
<b>CUPS</b>	CDC Undergraduate Public Health Scholars Program
<b>DFO</b>	Designated Federal Officer
<b>FOA</b>	Funding Opportunity Announcement
<b>HDS</b>	Health Disparities Subcommittee
<b>HHS</b>	(United States Department of) Health and Human Services
<b>HIV</b>	Human Immunodeficiency Virus
<b>HP</b>	Healthy People
<b>IOM</b>	Institute of Medicine
<b>MMWR</b>	<i>Morbidity and Mortality Weekly Report</i>
<b>MSM</b>	Men who Have Sex with Men
<b>MV</b>	Motor Vehicle
<b>NACCHO</b>	National Association of County and City Health Officials
<b>NIH</b>	National Institutes of Health
<b>OMHHE</b>	Office of Minority Health and Health Equity
<b>OSTLTS</b>	Office for State, Tribal, Local and Territorial Support
<b>REACH</b>	Racial and Ethnic Approaches to Community Health
<b>STDs</b>	Sexually Transmitted Diseases
<b>US</b>	United States
<b>WHO</b>	World Health Organization

