



Minutes from the
April 24, 2013

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 24, 2013 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 24, 2013. Participants attended in-person at CDC's Clifton / Roybal Campus in Atlanta, Georgia and by teleconference.

Introductions, Roll Call, Welcome and Overview of Meeting

Dr. Lynne Richardson, ACD Chair and Designated Federal Officer (DFO), called the meeting of the CDC HDS of the ACD to order on Wednesday, April 24, 2013.

Ms. Gayle Hickman called roll and established that a quorum of HDS members was present either in person or via teleconference. A list of attendees is included in Attachment #1 at the end of this document.

Updates from the Office of Minority Health and Health Equity

Dr. Liburd extended her welcome to those present, and thanked everyone for their continuing commitment to the Office of Minority Health and Health Equity (OMHHE) and the HDS. She indicated that information regarding the CDC Undergraduate Public Health Scholars Program (CUPS) was presented to the HDS subcommittee in October 2011. At that time, the subcommittee members offered significant feedback. The CUPS program had a very successful first year based on the evaluations received last summer, and is anticipated to have an equally successful second year that will take place from May 28, 2013 through August 2, 2013. The decision was made to move the orientation component at CDC to the beginning of the program, which will be May 28-31, 2013. Upon completion of orientation, the students will begin their internships in their respective placement sites at CDC, state and local health departments, hospitals, and community-based organizations. OMHHE has also embarked on an evaluation project that will launch this year, through which significant program monitoring will be conducted of the process itself and of student progress for up to two years after they complete the program. There continues to be highly positive response in terms of the recruitment. Approximately 190 undergraduate students will participate in CUPS, and about 12 graduate students will participate in the James A. Ferguson Emerging Infectious Diseases Fellowship Program.

The Millennial Health Leaders Summit was convened on April 4-5, 2013 as part of OMHHE's celebration of Minority Health Month in April. This summit is conducted in partnership with the King Center in Atlanta, Harvard University, and Brown University. "Millennial Health Leaders" include graduate public health students, medical students, and public policy students. A nomination letter was sent to approximately 20 universities requesting that they each nominate up to 4 students from their universities, and to financially support the participation of their students in this program. The goal of the 2013 summit was to assemble the next generation of leaders who will be tasked to focus on eliminating health disparities in the United States (US) in the 21st Century. Attendance during the first summit was comprised of 58 students from 14 schools. The summit was structured to be highly interactive. The students spent a full day at CDC hearing from subject matter experts about the 21st Century challenges and opportunities OMHHE believes they will inherit upon entering the workforce. They spent the second day at the King Center. High school students were included in that forum so that they could meet the graduate students, hear the debates and conversations, and engage in discussions with them



about how they knew what they wanted to do and what led them to this point. This was a very productive two days, and OMHHE's goal is to maintain a connection with the Millennial Health Leaders, and create activities in which they can continue to be involved in over the next year. The summit is part of a larger OMHHE initiative known as the "Health Disparities Leadership Institute." The official launch of the larger initiative in August 2013 will coincide with the 50th anniversary of the March on Washington. The plan is to have some of the students in Washington in August, and to engage them on an on-going basis so that this is part of their professional development and mentoring.

The inaugural Forum on the State of Health Equity at CDC was convened on September 27, 2012. This was an agency-wide assembly of senior leaders from throughout CDC who engaged in a focused conversation about the elements that need to be addressed to achieve health equities in CDC's programs, and ultimately in the population. The major themes of the forum included the following:

- Measuring Health Disparities: An Essential Starting Point for Achieving Health Equity
- Essential Program Elements
- Organizational Structures that Support Health Equity at CDC
- Promoting Policies that Support Health Equity

The proceedings from that event are now available. An internal committee was created to continue to develop these themes, which will meet annually to further flesh out the components of the themes in order to make them concrete and actionable. A publication is planned to articulate the themes for the public health community and set forth an actionable health equity framework. The second forum is planned for October 2013.

This year in August will mark the 25th anniversary of the Office of Minority Health and Health Equity at CDC. Leading up to that anniversary, OMHHE began a process about two years ago of developing a collaboration with the CDC David J. Sencer Museum located in the Global Communications Center of CDC. The project is titled, "Health is a Human Right." It is a historical look at the factors impacting the evolution of minority health, with a particular focus on the social determinates of health. This exhibit is scheduled to open on September 28, 2013 on Smithsonian Museum Day when all museums across the country are open at no charge. Last year, approximately 800 people visited the CDC museum on Museum Day. Dr. Liburd expressed her hope that HDS members would have an opportunity to visit this profound and moving exhibit that is representative of all of the racial and ethnic groups.

Discussion Points

Dr. Ro inquired as to whether Dr. Liburd could comment on the diversity of the 190 undergraduate and graduate students in the CUPS program.

Dr. Pestronk recommended contacting a similar and very successful program for undergraduates at the University of Michigan's School of Public Health to inquire about their lessons learned over the past 20 years. He commended OMHHE for their work in this area.

Dr. Liburd replied that Michigan's School of Public Health is one of the OMHHE's grantees. The other grantees are Columbia University in New York, Kennedy Krieger Institute in Baltimore, and Morehouse College in Atlanta. Each university was funded to select up to 50 students.



However, given the recent budget cuts they may not be able to recruit 50 students. Last year, there were just under 3,000 applicants for those 200 spots.

Pointing out that health equity is a national issue, Dr. Ross inquired as to what other organizations are involved in the Forum on the State of Health Equity at CDC. He stressed that in discussion of health equity, it would be implausible to say anything concrete unless it was addressed in all federal policies at the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Healthcare Research and Quality's (AHRQ), and so forth. He wondered how those voices were being captured in that forum.

Dr. Liburd emphasized that the spotlight during that forum was focused intentionally inward within CDC to examine the agency's minority health and equity efforts as a whole. One of the goals of OMHHE is to provide leadership across the agency in minority health and health equity, so representatives were convened from throughout CDC to discuss what they are doing. Ideally, the goal is to establish a standard across the agency. Directors of other federal agency's minority health offices were invited. Dr. Cara James, Director of the Office of Minority Health at the Centers for Medicare and Medicaid Services (CMS), was part of the forum. She discussed policies that support health equity, and spoke from the standpoint of the Affordable Care Act (ACA). While the other invited directors were unable to attend, CDC certainly is sensitive to obtaining input from them and ensuring that what is reflected in the state of health equity at CDC is consistent with good public health science and practice. Other federal agencies like SAMHSA, AHRQ, and FDA have different mission statements. While CDC recognizes the importance of working together, it is also important to ensure that the agency as a whole has a solid perspective on advancing and achieving health equity.

Dr. Ro thought the Forum on the State of Health Equity at CDC was fabulous, and she wondered what HDS's role might be related to advancing the state of health equity within the agency.

Dr. Richardson agreed with the importance of determining HDS's role, but requested that they hold this discussion until later in the day during the session focused on potential HDS contributions.

Dr. Botchwey expressed an interest in the October 2013 Forum on the State of Health Equity at CDC, and wondered whether the HDS subcommittee meeting could coincide with it.

Dr. Liburd noted that the October 2013 HDS meeting would probably be a teleconference. Dr. Richardson added that it was her understanding that due to financial constraints, there would be one in-person meeting and one teleconference each year for the ACD and HDS. She suggested that consideration be given to switching the teleconference and in-person meetings for the HDS so that the members could attend the forum and visit the museum.



Recommendations to be Presented to the Advisory Committee to the Director

During this session, Dr. Ross offered a brief overview of the history of the recommendations. He explained that based on previous meetings with the Institute of Medicine (IOM) Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, Dr. Liburd asked the HDS to develop concrete recommendations. Drs. Ross, Ro, and Duran were tasked to review those proceedings, tease out actionable items, and provide draft recommendations to the full HDS for review and feedback. That process occurred over a period of approximately 9 months, with a goal to ensure that the recommendations were consistent with the mission and goals of the entire public health enterprise. Subsequently, Dr. Liburd abstracted the resulting recommendations into more formal recommendations. During this HDS meeting, Dr. Richardson led the members in a discussion pertaining to the following presentation about the recommendations that she planned to present to the ACD the next day. The HDS input follows each recommendation:

Recommendation 1

Develop a CDC framework for action to achieve healthy equity:

- Describe indicators, measures, and tools for monitoring trends in health equity
- Identify evidence-based approaches and essential program components to address healthy equity
- Clarify organizational structures that facilitate integration of health equity in programs and research
- Identify and promote 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

- Make the recommendations read more like a conceptual framework or logic model that codifies them into a systematic, measurable model to help guide the implementation of the recommendations.
- One question that the ACD may pose is, “How does the first bullet under this recommendation differ from the 2011 Health Equity Report and the upcoming 2013 report that will be released?” It is important to be prepared to respond to that question.
- Perhaps the second bullet under this recommendation should reference the *Community Guide* and highlight the desire to conduct a more detailed review of health equity issues as they relate to the various components presented in the *Community Guide*.
- Also with regard to the second bullet, it is important include elements of comparative effectiveness. There has been significant push-back from communities about the tendency of federal and state governments to support only evidence-based interventions when there is insufficient evidence for such intervention in communities of color.
- Part of the challenge is that, while it is very exciting to have an Office of Minority Health and Health Equity within the CDC, it is a small office. Part of the goal of the third bullet point regarded integration of health equity in programs and research, and embedding and



integrating health equity throughout CDC versus having it as a stand-alone program—a reaffirmation of and commitment to further health equity throughout the agency. This involves assessing the differences in policies and practices throughout CDC to embed health equity, and changing the language within all of the funding opportunity announcements (FOAs) to address this. Every CDC program or division should be held accountable for integration of health equity.

- ❑ There should also be accountability throughout the Department of Health and Human Services (HHS), in particular with regard to Health Resources and Services Administration (HRSA), because of its focus on service delivery. HRSA is very much interested in integration with CDC. This is the most effective way of reaching the target audience, given that millions of people are served through HRSA-funded community health centers.
- ❑ The third bullet requires more clarity regarding whether it pertains to creating organizational structures that facilitate the integration of health equity. Of all of the HHS agencies, the public health field turns primarily to CDC for public health systems and services research. That idea is to build a system of accountability. There remains a real question about the definition of what OMHHE is intended to do and how it operates. The understanding was that it was never the intent to have all programs and funding for health equity run through this office. It is important to develop a standardized definition for “health equity” and establish mechanisms to ensure that every division and program within CDC is aware of that definition and assess the degree to which they are linking it to their work.
- ❑ OMHHE did not develop indicators in advance and then simply ask for comments. The model called “The State of Health Equity in CDC” was used and representatives from the entire agency were assembled to discuss this. The intent was to ensure that everyone across the agency was engaged in this effort collectively in order to achieve buy-in throughout CDC. Though the process is longer, it increases the likelihood of institutionalization.
- ❑ To address the gap of lack of coordination across programs, the notion was to develop some measures that might be the same across centers so there would be some reasonable comparison of how each center is addressing health equity and health disparities reduction.
- ❑ The distinguishing feature of the first recommendation is that it is not an action plan. Perhaps the word “clarify” needs to be changed, but it seems fine as a recommendation for a framework. The specific recommendations moved beyond words like “identify” to words like “promote” “support” and “build.”



Recommendation 2

Identify and monitor indicators of health equity:

- The periodic CDC Health Disparities and Inequities Report (CHDIR) is a seminal resource for the nation in monitoring health disparities and inequalities
- As data are available, CDC should report on disparities experienced by people with disabilities, sexual and gender minorities, people living in rural areas, and other socially disadvantaged population groups
- This recommendation is consistent with Section 4302 of the Affordable Care act

HDS Discussion Points/Suggestions

- The recommendation is not for something different from the current periodic publication of the CHDIR. It is to continue to grow, evolve, and build upon current indicators and identify additional indicators.
- The second sentence should state, “As data are available” rather than “As data is available.”
- As part of having CDC move toward a cutting-edge and innovation, from a community approach, it is important to include assets in addition to disparities. This is especially reflected in the work that health departments and non-profit hospitals are having to do around community health needs assessments.
- The first bullet might be something along the lines of “select particular indicators,” and the operation term is “trend.” It is no longer just about finding things to measure. It is important to discover whether a difference is being made over time. One bullet could focus on the trends and another could focus on having the agency select particular indicators, or work with communities to select particular indicators.
- Be careful about making a recommendation to encourage local communities to collect data, particularly with respect to sexual orientation and gender identity. Collecting data within those populations can be challenging because it depends upon how the questions are asked. For the first time, the National Health Interview Survey (NHIS) is going to start collecting data based on sexual orientation this year and in a couple of years on gender identity. It took years to go through a cognitive testing process to make sure the data collected are reliable. It would be preferable to keep the language in the recommendation and make sure the data are being collected reliably so that they can be studied appropriately.
- In terms of selecting indicators and the trends from a practical perspective, many health centers nationally are moving toward the use of electronic health records (EHRs) and participation in Health Information Exchanges (HIEs). There is not a consistent question in EMRs pertaining to people’s occupations, and morbidity and mortality are not reported by occupation. Simply asking about primary occupation would allow for assessment of disparities by population group, geographics, ethnicity, and occupation.
- There is no mention of “Healthy People 2020” in the recommendation. Consideration should be given to making the recommendation consistent with “Healthy People 2020.”



Recommendation 3

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

- ❑ 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 (CTGs), are models 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

- ❑ One of the challenges, especially for minority communities and emerging communities where there is not an evidence base, is making sure that innovative practices or practical experiences of communities are recognized. Otherwise, the efficacy of practices and interventions is limited only to what has managed to make it into peer reviews.
- ❑ The CTGs are critically important in terms of how structure really could galvanize communities to address specific issues. It could offer the capability of smaller communities to actually compete for such grants, and to leverage their own resources for such CTGs.
- ❑ The language of “universal interventions and targeted interventions” was used in the *2011 Health Disparities and Inequalities Report*. The language can be changed if something else would be clearer. It is similar to showing a calorie count, which is a universal intervention because it is intended for anybody who picks up a menu or walks into a fast food restaurant. An example of further targeting that type of intervention would be to offer additional information to certain communities (e.g., low income, communities of color, et cetera) about what those calorie counts mean, how to keep track of them, and how many calories should be consumed in a day. The benefits of universal interventions are not as obvious to some communities. Even with clinical interventions, there is a need to be sensitive to cultural competency in terms of healthcare disparities.
- ❑ Some people think about “community” in the geopolitical sense, but the way it is being used in this recommendation is as populations of people with one characteristic or another. Dr. Frieden recently had an article published in the *New England Journal of Medicine* in which he references some of these same kinds of ideas. Perhaps, since these recommendations are designed to be presented to Dr. Frieden, the language should align with the language of his article to help him understand what the HDS is recommending.
- ❑ In addition to the CTGs out of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), the National Center for Environmental Health (NCEH) has the Healthy Community Design Initiative (HCDI). NCEH’s efforts focus on activities such as health impact assessments in small, medium, and large communities. They have also engaged in a lot of work pertaining to water quality, park access, sidewalks, amenities, land use that leads to more walkability, better community design, et cetera to achieve positive health outcomes. The work of these groups is complementary and should be mentioned in this recommendation along with some examples, using Dr. Frieden’s language.



- ❑ Racial and Ethnic Approaches to Community Health (REACH) could be included as an example in this recommendation.
- ❑ For communities of color in particular, there is still a need for interventions and support related to building capacity for program and service delivery. One of the challenges with CTG is that there has been a shift from talking about policy to advocacy. However, part of the role of public health departments should be to set policy, or to help create and inform policy decisions. REACH is a great example of where the shift to working on systems and policy has basically eliminated the culturally competent services, at least in King County. As part of the prior REACH grant, an entire network of providers and organizations was built to provide culturally competent health management services; however, that was not sustained. When the new REACH grant was published, with a shift from delivery of culturally competent services to policy and systems change. The network of REACH providers is no longer funded, and has essentially disbanded. This is a major problem, assuming that only hospitals and to some degree health plans are the only entities that will provide services that hopefully are culturally competent. Trickle-down does not work in addressing the inequities in some communities.
- ❑ In theory and intent, this recommendation is intended to re-engage exactly what was taken away. There are people in the public health community who believe that policy changes are more efficient, do not require the same amount of oversight and management, cost more, and only reach the people who are engaged. When funding ends, these programs end. Data from New York have suggested that, in some instances, implementing universal interventions worsens disparities.
- ❑ This recommendation is trying to refer to the collection of communities that are at risk of health disparities. It is important to consider whether the jargon is acceptable to different communities that are being referenced in this recommendation.
- ❑ The wording “communities at highest risk” was taken directly from the National Prevention Strategy.



Recommendation 4

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

HDS Discussion Points/Suggestions

- The Center for Culturally Responsive Evaluation and Assessment (CREA) is a national center that has begun to consider ways to make more culturally responsive, relevant, sensitive, nuanced, rigorous evaluation of programs in all sectors. One issue that arose among the individuals who developed that center is the importance of evaluating indigenous practice that certainly have legitimacy at the local level because there is traditional evidence that they help people. Those practices should be submitted to rigorous evaluation with a consideration of the cultural nuance inherent in them.
- It is not clear whether this recommendation is asking for financial support for rigorous evaluation.
- “Support” in this context refers to instituting rigorous evaluation in CDC programs, and requiring this of grantees that receive external funding. It refers more to leadership than financial support, and focuses on improvements in health from universal interventions that are smaller, targeted, and culturally tailored in order to produce evidence about their impact.
- In that case, that means that the health disparities for American Indians /Alaskan Natives (AI/AN) or others not impacted by a universal intervention actually become worse.
- “Support” should include financial support, because there have been numerous instances in which FOAs have been published and grants awarded, but there are not sufficient funds to conduct evaluation. A good example of evaluation deeply embedded in a new program is in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program through HRSA in which recipients had to adopt evidence-based programs. Sometimes the evidence was not very robust, but a promising program was scaled up in a way that would allow for rigorous evaluation.
- Part of this support should also include guidelines or a framework that would help evaluators who are not familiar with this context to conduct culturally specific, tailored evaluations. This might involve a commissioned paper or CDC working with evaluators. Perhaps CREA could produce guidance or a framework for this that is a dual-focused evaluation on health equity.
- Understanding these interventions, especially those focused on policy and systems changes, can take longer than two or four years for the impact to be realized.
- Perhaps, the recommendation could state, “We support the conduct of rigorous evaluations of universal and targeted interventions, and where implicated, an appropriate evaluation strategy to establish best practices.”
- Given that particular tools are promoted by particular groups for certain kinds of interventions, someone should review other tools being promoted. Perhaps there ought to



be an evidence base to suggest which is the best tool before recommending it. There should be a consistent approach once the approach is identified.

- ❑ Dr. Richardson indicated that she would frame her remarks by observing that there are places within the agency where all of the recommendations are being fulfilled to a greater and lesser extent, and that this list of recommendations is not intended to suggest that none of these things are happening now. However, there should be an agency-wide effort to coordinate, standardize, and integrate all of these activities in order to leverage the efforts to move the health equity work forward as far as possible.



Recommendation 5

Build community capacity to implement, evaluate, and sustain health equity programs, 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

- It is not programs that are going to create equity—it is policies. It will be those efforts that are made for both communities at highest risk of disparity and for the universal population that create conditions which make it easier for people to be healthier. There can be all the programs anyone wants, but there will never be enough of them. There is currently a set of policies in place that result in the inequity in this country.
- It is not either/or. Both programs and policies are needed. Sometimes a policy might be good to have, but the failure is not the policy—it is the implementation and oversight to ensure that the policy is enforced.
- Policy probably does not need to be included in this recommendation because Recommendation 1 explicitly addresses policies that transform communities and transform behavior. The last bullet point in Recommendation 1 outlines that, “Identify and promote policies that support reducing health disparities.” Recommendation 5 is drilling down to the community level to ask, “What programs can be implemented at the community level that will inform that policy?”
- A friendly amendment to consider would be that sometimes programs evolve into policy, and many times there are programs for which there is not just bad policy, but no policy at all. This is especially true in highly rural areas. Sustaining programs can be done through policy reform, whether it is adoption or modification.
- The politics of this is that programs or policies should not be labeled as “health equity programs or policies.” Too many people will perceive that as being for “only for those folks over others.”
- It is actually a success to bring this recommendation forward to build community capacity, because it is asking people to step outside of their comfort zones to seek resources where they usually do not, if for no other reason than it is not going to be clear to those who control the resources that the money is going to get spent the way they want it spent. Part of that is because they are still looking for the outcomes described earlier. The recommendations create a portfolio of activities that demonstrate that public health occurs in many different sectors. It is not all in government, all at the local level, or all at the state level. Community-based organizations are the most challenged.



- These are programs and policies that, as an end product, promote health equity. It is a combination of programs and policies, because policies provide a population level framework to guide programs, investments, and individual and group level interventions that filter out to a population level. With that in mind, both programs and policies should be included in this community-focused recommendation.

- Health policy is everywhere, and health in all policies needs to come forward in these recommendations.



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 to ensure a diverse workforce prepared to address emerging public health issues, including achieving health equity

HDS Discussion Points/Suggestions

- It is pleasing to see this recommendation about training and professional development. Reflecting on what used to be called the “Hispanic Agenda for Action” is now set in a set of Executive Orders focused on health professions training at all levels for all disparate populations.
- Consideration should be given to how the capacity-building and workforce development recommendations can be built into requests for applications, so that communities receiving CDC funding, could have a scope of work or objective specific to public health capacity development. Perhaps a small amount of CDC funds allocated to the community could be used to train people from that community for workforce development.
- In presenting this to the ACD, calling out racial and ethnic diversity specifically in terms of a diverse workforce is really important, particularly at the leadership level. In some public health conversations regarding a diverse workforce, there is a move to think of diversity in a different way, which is diversity in terms of the skillsets needed in the new world of public health and the built environment, and affecting policy and systems change. Racial and ethnic diversity do not always go hand in hand with this. The second piece of that is to have diversity reflected within CDCs leadership and in its advisory committees overall.
- It is important not only to consider the pipeline written about in the sixth or seventh line down, “continuing to support pipeline programs,” but also to consider retraining or continuing education that would be offered to the current workforce. That is a much larger population than the pipeline.
- An element of disability diversity needs to be added or connected to the racial and ethnic training—something related to inclusion training in combinations in the workforce for people with disabilities. There are certain elements of inclusion that have to be considered in any kind of a broad campaign to support training and professional development.

At the conclusion of the discussion of the recommendations to be presented to the ACD, Dr. Richardson indicated that she would incorporate the suggestions and would email the revised version to everyone to review during the evening.



Overview of the 2013 CHDIR

During this session, Rachel Kauffman presented information regarding the *2013 Community Health Disparities and Inequities Report (CDHIR)*. She thanked the HDS for its interest in this report, emphasizing how exciting it was that the members were reviewing it so closely. She explained that although the report has been referred to as a “biennial report,” the 2011 version was the only publication to date. While it is now referred to as “the first in a periodic series,” the expectation remains to publish this report every two years. The 2013 report is nearly completed, will go into the editing and production phase soon, and is anticipated to be published by late summer or fall of 2013. The 2011 report took a broad view of disparities across a wide range of diseases, behavioral risk factors, environmental exposures, social determinates, and healthcare access.

The 2013 report is similar, but there are some changes. The 2011 document had 21 topics, while the 2013 report has 19. It includes updates on topics that were covered in 2011, except air quality and housing quality since the programs did not have updated data for those two topics, as well as nine new topics. The topic selection criteria for 2013 were the same as they were for 2011. Topics included in the report were chosen because they met one or more of the following criteria: leading causes of premature death among certain segments of the US population; social, demographic and other disparities in health outcomes exist; effective and feasible interventions exist to address health outcomes; and high quality data were readily available from national health monitoring systems. “High quality” in this context means the data are believed to tell the truth, not necessarily that the data include all of the variables they wish it included.

An attempt was made to standardize the methods used to identify and present disparities. The workgroup planned the report very carefully, giving a lot of thought to what should be included and how these factors should be assessed.

They also standardized the report so that it would be easy to read, easy to absorb, and easy to move from one article to the next without having to completely reorient. The authors were asked, if appropriate, to use a standardized set of population segments, and within that to break it down into particular categories. That made sense for some topics, but not for others for which data were not available. The variables requested included sex, race, ethnicity (non-Hispanic white, non-Hispanic black, non-Hispanic other), Hispanic as a category of its own, age (mostly 10-year age groups), nativity (born in the US / US citizens or not), language spoken at home (English, Spanish, or other), disability status (with disability / without disability), sexual identity or orientation (homosexual, heterosexual, or bi-sexual), geographic area (varied depending upon the topic), socioeconomic status, educational attainment (high school, less than high school, high school equivalent, some college, college, or more), and income in terms of the federal poverty level using the National Center for Health Statistics (NCHS) classifications.

The authors of these analytic essays were asked to create a somewhat standardized presentation of the data for comparisons purposes and ease of reading. The base measure for each of the essays will be a percentage of prevalence or a population rate per 100,000. The authors were also asked to assess the simple difference between the categories of each factor. For example, males and females are compared for “sex.” The simple difference is just one minus the other, and usually the referent category will be the category with the best situation, whether it is for a determinate or a health outcome. The next is the relative difference, where it is the percentage difference from that referent group. In most of the essays, these data are



given for the years 2006 and 2010. The final one assesses change over time. This is usually a column evaluating the simple difference in the relative difference, or subtraction of the relative difference in the second year to the first year, which tells whether a disparity is growing wider or narrower. There are percentages and rates depending on which factor is being addressed. The first column of data, depending on the topic, will be a percent prevalence (people who have Factor X), or it will be a rate in the population (a rate per 100,000).

With close to 30 essays, there are numerous challenges. There are a number of data sources, including national surveys primarily from CDC, state-based data, data from other institutions such as air quality data from the Environmental Protection Agency (EPA), food retailer availability data from the United States Department of Agriculture (USDA), hospital cost data, et cetera. Collection of data on the population segments of interest is not necessarily standardized. Though the authors have been asked to standardize to the extent possible, this is not always possible and is not always appropriate depending upon the topic. For some groups, there simply are not a lot of data. This is particularly true for sexual identity and for disability. Of the 28 articles that are going to be included, most assessed age and sex. More than half assessed education. Only 10 were able to include nativity, 9 have disability, 4 have covered the language spoken at home, and only 1 has data on sexual orientation (the article on HIV infection).

There is a major question regarding the best method for measuring disparities. There was significant conversation regarding whether to calculate a simple difference, a relative difference, a difference of the difference, a difference of the relative difference, or a relative difference of either of those. There is no agreement among the literature. The workgroup felt that it was important to choose measures that the readers, who are anticipated to be comprised of a broad range of individuals, would understand. Descriptive analyses are used for simplicity, understandability, comparability, and presentation. Confounders are not included, which limits interpretation.

Working with almost 30 different author groups is extremely labor-intensive. The workgroup wanted this report to be valuable and useful for all of the work on the part of all of these people (e.g., authors, analysts, reviewers, managers) throughout the agency. When the first report was published a couple of years ago, it did not make a big media splash. The extent to which it might have influenced program directions inside and outside of CDC is unclear at this point. Consideration has been given to focusing on fewer conditions and determinants, and perhaps having a set of sentinel determinants. It is really difficult with 30 different essays to identify one overriding message. It might be easier to develop a focused, meaningful message if fewer variables are included. Consideration has also been given to using fewer data sources, which would make it easier to standardize the measures. Conversely, that means eliminating some of the information that has previously been included. There is a trade-off between comprehensive in topics and comprehensive in population groups when looking within topics. Thought has been given to using a website instead of a report, given the production cycle of *Morbidity and Mortality Weekly Reports (MMWR)* supplements, which takes several months. A website could include links to the individual programs, which update their own data as they become available. It would include a nice graphical interface so that a user could go to the website, put in what they are looking for, and receive something back that is meaningful and fairly easy to understand.



Paula Yoon emphasized that the Community Health Needs Assessment health improvement activities are spread broadly across the agency. The Office of the Associate Director for Policy (ADP) has recently taken on the role of convening groups across the agency that are working in this area.

The Office for State, Tribal, Local and Territorial Support (OSTLTS) is engaged in outreach, partner engagement, and work with those in the field who are actually carrying out the work. For many years, this group has been developing the indicators that are being used for some of the CHNAs. A monograph was recently completed that should be published in the next month or so that evaluated all of the published recommendations for CHNAs and assessed all of the common indicators. Across 10 different guideline documents, 45 indicators had been recommended for CHNAs. The monograph discusses those indicators, as well as data sources to measure and analyze those data. While most of the CHNA data are secondary, the communities are also required to conduct a community opinion survey. The data from those surveys have been combined into an Epi Info™ resource, which is a software product. There is now a library of community opinion surveys, with validated questions that people can use. A related activity is the Community Health Status Indicators Project (CHSI). This is a website of about 300 indicators for all of the counties in the country (n= 3141), which was run by HRSA. In the past year, HRSA transferred that activity to CDC. CDC is updating all of the CHSI data, narrowing the number of indicators and making sure that it is in sync with the CHNA work. Links are provided to relevant *Community Guides*. The website can be found using the following link: <http://wwwn.cdc.gov/CommunityHealth/homepage.aspx?j=1>. The website is currently as it was with HRSA, but CDC is in the process of totally revamping it, and expects to launch the new version in January 2014.

The HDS members were invited to offer their thoughts and suggestions regarding the 2013 version of the *CDHIR*.

Discussion Points

Dr. Pestronk stressed that having a web-based version of the document would be a much better format than a paper-based document because data could simply be added into the web-based report at the time those data become available.

Dr. Ro pointed out that for a credible report of this caliber, it would be remiss not to at least allude to housing data. This could be done in the footnote, but the document will not be complete without these data.

Dr. Ro urged CDC to adopt the new guidance on race and ethnicity that disaggregates Asian Americans, Pacific Islanders, and Native Hawaiians. It is understood that these are small categories, but this offers the opportunity to have a conversation with those communities about how/whether they want their data presented. To continue to aggregate them does an injustice to those communities. This is a major issue for Asian Americans, Native Hawaiians, and Pacific Islanders.

Dr. Richardson noted that HDS would like a more detailed presentation regarding collection of these data, and data monitoring efforts. Because this is central to the issue of disparities, it would be beneficial to understand all of CDC's current efforts.



Dr. Ross suggested putting everything in a much more compartmentalized manner, with the inclusion of an executive summary outlining some of the highlights, putting social determinates into the proper context and expanding it to address all of the social factors, and a link to the comprehensive document in the website.

Dr. Yoon replied that consideration is being given to a centralized website that focuses on disparities, where they would have control of the data and would work with the programs to develop graphs, charts, maps, and other useful means for conveying the information. There would be links to the various programs throughout CDC that are actually doing the work to address the disparity. This would offer a lot richer information about what programs are doing than the report that just focuses on the descriptive data.

Dr. Ro reported that the Seattle & King County local health department is faced with many of the same challenges CDC faces in terms of disseminating data in ways that are usable. As a resource, she encouraged the agency to consider the global burden of disease work by the Institute for Health Metrics and Evaluation (IHME) based at the University of Washington. They have a website for data junkies. For those interested in global health, there are very nice visualizations and a new conceptualization of looking at trends and data in ways that people can readily grasp. Having more reports may not be necessary. There are so many sources of data, sometimes it is difficult to drive audiences to it. In terms of sentinel indicators, while linking to CDC is appreciated, health is local. Seattle & King County looks at data at a sub-county level. What was discussed during the last meeting with IOM was a place- and race-based approach. However, that is not how data are presented. In terms of trends and the point that was made about how there is not very much difference in two years, that is also not how trend data are assessed locally because the impact of interventions on population outcome takes longer than two years. Perhaps a recommendation to ACD might be to consider whether valuable resources should continue to be placed on having numerous people writing reports, or if there should be support for people at the local level in getting the data that they need through health departments.

Dr. Liburd agreed with Dr. Ro that health occurs at the local neighborhood scale. The difficulty with health data is that they are easily accessible at the county level, but not lower than that, at least nationally. A recommendation of paramount importance is the ability to acquire reliable health data at a lower than county level.

Dr. Mullen pointed out that the challenge is to address both issues. Health happens at the local level, and a lot of the health improvements that need to happen are going to occur from actions at the state or federal level rather than the local level. However, because they were talking at the level of CDC, she understood the importance of ensuring that CDC is reflecting an eye toward the greater population and not just the populations in communities. There is a need to have local data, though it will be a challenge and requires further consideration. There are county and state health rankings and numerous measures. Again, consideration needs to be given to assets. Many disparities reports are the next version of articulating lack of improvement or slow improvement. That is somewhat different from an equity report that also describes the inputs and processes that ultimately are believed to be moving in the right direction. That is also not going to be specifically local because a lot of the policy and systems changes in many places are not going to occur at the local level.



Dr. Ro suggested that there was a great opportunity for partnership and engagement with a number of stakeholders. The only way to know the value of these data is to reach out to the stakeholders to ask whether these are the kinds of data they want and if they are using the data.

Dr. Schneider supported the notion of a website as a way to disseminate this information. As someone who advocates for the needs of the lesbian, gay, bisexual, and transgender (LGBT) community, it is always frustrating to hear that HIV is basically the only disease outcome for which sexual orientation is reported. When considering the recommendations that would be presented to the ACD the next day, he wondered whether there was some kind of push-pull in terms of a need to go back to other people within the agency to emphasize the importance of filling the gaps in data for certain populations.

Dr. Richardson responded that she had a very similar reaction. There are multiple audiences for this information, whether it is the report as it has been written in the past or it becomes a website. Recognizing that the world is not populated entirely by data junkies, there is a need for some people to have a written narrative that describes and explains the data. She did not feel that they had to try to make a choice about which is more important. Instead, they needed to think about how to get this information to all of the various important audiences. The model of having a biennial report and all that it implies in terms of the currentness of the data and the work involved may not be the best use of resources, but it should not become specifically linked to data streams that are not organized as the kind of standardization process that was engaged in. She liked the idea of having a dissemination plan for sending information out from the agency in small, easily digestible pieces whether it was by topic area, population group, et cetera. She also agreed with the importance of working with all of the stakeholders to understand who would be interested and how they want to receive data. She was troubled by the idea of a few sentinel indicators, because then there is a loss of access to the data on everything else. Perhaps there could be some indicators with more analysis presented, with trending and so on.

Regarding the conversation about the county-level data, while it makes sense, to provide this type of report at the county level would be highly difficult because all of the trouble that occurs with national level data is magnified by over 3000 counties. There are tremendous gaps and there is tremendous inconsistency; however, it remains unclear how this can be addressed.

Dr. Ro responded that multiple communities have to be targeted with different types of products. Pooled data are needed that can be manipulated, mapped, et cetera. Non-profit hospitals need the data in a digested format so that they can target their service communities. Someone interested in a specific disease or condition oftentimes will go to a specific program's website. It would be nice for every single program or division website to include a health equity data section that would allow for a deep dive into the disparities data of that.

Dr. Yoon responded that in this particular report, most of the data sources are large national datasets the NHIS and others. Very few of these data sources are disease-specific surveillance systems that individual programs are running. One effort that has come out of the ACA is this HHS Data Council. This group is making recommendations for the different segments of the population that should be included in all national surveys. NHIS is currently in the process of making sure that all of the major systems they run include this list of segments of the population and the various categories for which they need to collect the data. For example, sexual identity data are already being incorporated into the NHIS. Several of the topics that will be in the 2013



CHDIR actually had some data on sexual identity, but the HIV report was the only one where they could report it. A lot of the data are currently being withheld as they are being validated by that national center, which does not believe the data are robust enough yet to include in what CDC is doing. There is an initiative across HHS to ensure that all new data systems are collecting this information. All federal data systems are going to be required to collect this information, except for the disease-specific surveillance systems that probably do not have the availability to collect some of the information because they are using data sources like EHRs, physician reporting, or reports to health centers and some of the information is not being collected. To the extent possible, everybody is being encouraged to adhere to the HHS Council recommendations.

Dr. Pestronk inquired as to whether there was a link into the Meaningful Use requirements, and how CDC can contribute to the Office of National Coordinators (ONC) discussion in an effort to contribute to influencing the meaningful use requirements in the future. This would pertain to the EHR database and including the kinds of data the HDS had been discussing as a regular feature of clinical reporting. Obviously, not all of these data would be relevant, but some of them would be.

Dr. Richardson thought that most of them would be. The public comment period recently closed on recommendations regarding Meaningful Use. She participated in some contributions to that regarding the issue of collecting patient race and ethnicity data, language, and some of the other variables discussed early. Though the process continues, it is probably close to the decision-making stage at this point. She was not aware of CDC's role in that, or whether it was a reasonable suggestion for HDS to offer input.

Dr. Yoon responded that CDC has been participating in the discussions about Meaningful Use, primarily emphasizing the need to collect some of that data for public health purposes. A broader group has been working on the demographic components of Meaningful Use. There are a number of challenges with adding all of these additional variables to the dataset. There has been a lot of pushback from the clinical community and vendors that develop the EHRs, so it is a very challenging area and there may be tradeoffs.

Dr. Ryder agreed with the need for something for multiple audiences. For those who are not data junkies, packaging the numbers with the reality illustrated by efforts such as the museum display is a very helpful way to display the information. Consideration should also be given to mapping "circuits." Currently, a shotgun approach is taken to information dissemination. Sending out tweets, emails, et cetera is fine, but it is important to think about key groups that can, in turn, further disseminate the information. If the first two to three layers are mapped out, the viral system can be depended upon to get it out further beyond that. It is pleasing to see that the 2013 content includes unemployment, high-risk work environments, and cigarette smoking. Dr. Ryder suggested that not only are high-risk work environments important, but also people work 12 to 13 hour days 6 days a week, have an hour-and-a-half commute each way, and then sit in a sedentary job. Though not considered high risk individually, packaged together, that becomes a very high-risk situation for cardiovascular disease, children being neglected at home who get into bad circumstances, et cetera. Employment is closely tied to disability, and employment and disability can be an unemployment factor. She works closely with HRSA-funded programs, and there is a series of performance measures that are mandatory for the Uniform Dataset that is produced by HRSA regularly. It would be beneficial to



double-check the list of performance measures against the CHDIR list to determine whether any of the performance measures can feed into the list.

Regarding the employment data, Dr. Yoon indicated that the challenge is that while the Department of Labor has considerable data on employment, they do not have data on employment that is tied to health outcomes. The analysis in this particular report comes from the Behavioral Risk Factor Surveillance System (BRFSS) which asks questions about employment and questions about health. The challenge with many of the topics is finding a dataset that includes the demographic or the socioeconomic information, as well as the health outcome data.

Dr. Ro noted that the California Health Interview Survey (CHIS) includes a discrimination module and plans to implement this module in the next round. It is important not only to point out where health disparities and inequities exist, but also to remind people of what that framework is around health equity. If discrimination is an element that HDS strongly believes to be a major factor, consideration must be given to the degree to which they are using data to remind everyone that this is where they need to go.



Presentation by and Discussion with Dr. Colleen Boyle, Director, National Center on Birth Defects and Developmental Disabilities

Dr. Boyle began by introducing additional National Center on Birth Defects and Developmental Disabilities (NCBDDD) members who joined her, Drs. Gloria Krahn and Dr. Vince Campbell. Dr. Krahn is the Director of the Division of Human Development and Disability, which includes the Early Hearing Detection Intervention Team (EHDI), the Disability and Health Branch, and the Child Development and Disability Branch. Dr. Vince Campbell is also in the Division of Human Development and Disabilities where he serves a unique role at CDC. He functions as a liaison to the Office of the Director (OD), and serves as one of the key staff for an inter-center workgroup focused on the integration of disability within the context of all of CDC's related activities. Dr. Boyle also recognized Dr. James Rimmer, who has been a long-term advocate, scientist, colleague, and friend to NCBDDD and the work this center does to promote health among people living with a disability.

NCBDDD is a relatively small center that was formed in 2000. It is the only center at CDC that was formed as a result of an Act of Congress. In 1999, some advocates wanted to elevate issues pertaining to children's health to a higher level within the context of CDC. Within that mission, they also included issues pertaining to disability across the lifespan. The idea at that time was secondary prevention to ensure that people living with a functional limitation due to some underlying medical condition could achieve and live the fullest life possible in terms of their medical issues. Over time, that concept has transformed into health promotion and the recognition that people who have a functional limitation can be healthy. NCBDDD's mission is to ensure that people who are living with functional limitations have the same advantages as others. That fits nicely with HDS's context in terms of health equity and issues regarding disparity. When the center began 12 years ago, the name established by Congress did not reflect the diversity of the center's focus. While they are proud of the center's name because it reflects the origins of the center, they also recognize that there are numerous functions and people within the center that the name does not represent.

With regard to the public health concern relating to disability, the first context is to think about who people with disabilities are. Disability has a very heterogeneous face and may include children with spina bifida, military veterans who lost a limb due to an injury, aging individuals with the consequent mobility limitations, people who have diabetes and its consequent impairments, children with down syndrome, people who have cognitive disabilities, and others who experience serious limitations in functioning that could impair their health. The International Classification of Functioning, Disability and Health (ICF) published by the World Health Organization (WHO) is a taxonomy for disability that defines disability in terms of three features: impairment in body function or structure, limitation in activity, and restrictions in participation in daily activities. For people living with disabilities, there are major attitudinal issues though many people do not want to recognize or admit that. There are also many other barriers, and the center tries to focus on removal of those barriers from a programmatic standpoint.

Through significant epidemiologic research using some of CDC's hallmark surveillance programs such as BRFSS, NCBDDD has been able to show that people with disabilities across a broad spectrum of risk factors, health conditions, and healthcare access related issues are much more likely to have adverse physical health outcomes, lack of access to important services such as mammography, or have financial barriers to access to care. The most recent



data, which are from 2010, show that people with a disability are much more likely to report obesity, as defined by body mass index (BMI), relative to those without. There is approximately a 14 percentage point difference between people with disabilities and those without. Another top priority for CDC is reduction in cigarette smoking. Unfortunately, there continues to be a disparity in cigarette use among people with a disability. There is about an 11 percentage point difference between people who have a disability and those who do not. Very importantly, these data show that people with disabilities are much more likely to try to quit smoking. In thinking about all of the public health programs to try to impact people with disparities or with health inequities, perhaps people with disabilities are not being reached or are unable to take advantage of the smoking cessation programs available. Again, disability is a part of the human condition and should not be equivalent to poor health. Many times when people talk about poor health, they talk about disability in a very negative term and equate that with poor health. NCBDDD is trying to change the attitude.

Clearly, there are disparities. The question is: What are we doing about it? In terms of working across CDC to address the issues, CDC's core programs include public health surveillance, monitoring, and research. Essentially, NCBDDD is trying to integrate disability in the context of all of what CDC does. That includes focusing on CDC's core strengths, as well as health promotion, protection, and prevention. One of the mandates within the context of the ACA, which relates to other disparity-related demographic factors as well, was that disability has to be included as one of the demographic variables in all HHS surveys and programs. Fortunately, the HHS Secretary began working on this quickly after the act passed. At the HHS level, the decision was made that there would be a standard way to identify people with disabilities using the American Community Survey (ACS) questions. Those are the questions contained within the Census, and fortunately NCBDDD was able to integrate ACS in its own internal system.

Beginning in Fiscal Year 2013, all states that collect BRFSS data will include the ACS questions within the context of the BRFSS. Unfortunately, one of the questions on hearing loss could not be included because it is a telephone survey, and there was not a means to identify people with hearing loss through that context. In addition to BRFSS, CDC would like to integrate these disability questions within other data systems in order to have very rich data with which to describe people with disabilities and further understand the health disparities associated with them. The new questions will allow for assessment of the broad category of disability, as well as the functional level. This will enable NCBDDD to gain a better sense of who people are, what health circumstances they face, and what health promotion opportunities exist for them. In addition to the opportunity to characterize the population through data, NCBDDD has been working to influence CDC-wide policy to incorporate disabilities in the context of all FOAs the agency publishes. Dr. Boyle requested that Dr. Campbell offer further information about that policy.

Dr. Campbell indicated that the policy is currently under consideration and is intended to build on some language that was inserted into a revised template for FOAs for non-research program activities. These are funds that CDC allocates to the field for health promotion and prevention activities. Basically, the idea is that all programs will address the needs of people with disabilities, make their programs accessible. If they are using health communications, they have to address health literacy issues, offer alternative formats for printed materials, print captioning on videos, et cetera. Facilities in which health promotion activities occur should be accessible to people with mobility or vision problems. In addition to the policy, concrete efforts are being made with programs like the *Guide to Community Preventive Services (Community*



Guide). CDC contracted a study through the Public Health Institute in California to review 90 of the interventions recommended in the *Community Guide*, which is considered to be the gold standard of public health interventions. This systematic review assessed 15 of 20 of the content areas of the 90 recommended interventions for appropriateness for people with disabilities and accessibility issues. Virtually all were determined to be appropriate, while approximately a third needed work in terms of accessibility and/or training of healthcare or service providers to identify barriers and show sensitivity in working with people with disabilities. The results were presented to the Task Force on Community Preventive Services in June 2011, which is going to permit NCBDDD to develop a link from the recommended interventions to a resource website that is under development that will provide specific information for people writing FOAs regarding how to make their programs accessible.

Dr. Boyle reported that NCBDDD also wanted to venture into the world of research FOAs; however, this is going to be more complex. The center wants to ensure that everything they do is meaningful, rather than just checking a box that disability has been included. As part of Dr. Campbell's workgroup effort, an evaluation process will be developed. The workgroup will have 9 months to implement this effort, with a goal to gain a better sense of what meaningful change or impact has occurred. The goal is to retrain staff to think about people with physical, emotional, and behavioral issues and challenges and to put this in the context of the burden of the population relative to people with disabilities. Based on the most recent BRFSS, 1 in 6 Americans reports a disability. That is expected to go down somewhat because the new questions capture people with more serious disabilities. This is clearly an incredible population. They are heavy users of healthcare services and they have complex medical issues. This is due to the lack of focus on their healthcare rather than their disability. NCBDDD is attempting to use the power of CDC as a whole versus the center's program alone to make sure that people with disabilities can be healthier than they are currently.

Discussion Points

Dr. Botchwey inquired as to where mental health falls within NCBDDD's work and more broadly CDC's work.

Dr. Boyle replied that people with sensory, cognitive, social, and emotional challenges are considered within the disability realm. Within the broader disability context, there is not a specific focus on those issues. There are efforts within the Division of Human Development and disability to focus on children's mental health. Adult mental health cuts across a lot of programs at CDC.

Dr. Ro indicated that she chairs the HHS Advisory Committee for Minority Health, which published its own report in 2011 with a set of recommendations specifically focused on minority persons with disabilities. The report discussed the simultaneous oppression of being a person with disabilities as well as being a minority. There are also struggles with the BRFSS at the local level. One effort in which she has been involved has been reviewing contractors for BRFSS to ensure that they meet the Americans with Disabilities Act (ADA) in assuring equitable access and that new telephonic systems are in place that allow persons with hearing impairments to participate in the survey. It is increasingly important to push boundaries to assure that all populations can participate.

Dr. Campbell agreed that it is vital to have state and local level health data on populations. The BRFSS has included questions on disability in 2001, 2003, and continuously since then. There



were two questions that came out of a workgroup on *Healthy People 2010*, so when the new questions came out, they were somewhat different. They were based on the Washington City Group questions that were to be used internationally and provided a scaled response. The ACS questions were framed within a context of complete loss or serious difficulty. BRFSS is basically controlled by the coordinators of the state, who agreed to add the 5 questions that did not include the hearing question. They are retaining the two questions released in 2013. The disability questions are taking up about 10% to 15% of the real estate on the BRFSS, which is very difficult to accomplish. NCBDDD has had discussions with the BRFSS representatives about addressing Telecommunication Relay Services (TRS) that basically puts somebody who can translate between the person who has the hearing difficulty and the person asking the question. That introduces a confidentiality issue. They are also investigating the possibility of using an internet panel approach. A pilot study is currently underway that is asking all six questions, including the hearing question. It is based on an internet panel of volunteers who opt in, and while it is not population representative, they weighted to approximate the ACS demographics. At least in some political context, this approach is timely and appropriate. The point estimate agrees with the results, with a very narrow confidence interval, so they are getting some very good results out of this.

Dr. Krahn noted that additional testing is being done. Montana added some state questions on hearing, and identified that 11% of respondents still endorse hearing loss. While the issue is being revisited, for now only the 5 BRFSS questions will be added in order to move forward.

In thinking about health inequities, disparities are often not recognized in terms of building systems and policies that generate better social engagement for people at the lower end of the socioeconomic spectrum. People with disabilities have the highest unemployment rates, some of the lowest socioeconomic status, and some of the lowest educational levels. Anytime they talk about health, they must never forget the importance of ensuring that people with disabilities are included. In the last five years of work that has been ongoing within NCBDDD, he has observed a tremendous volume of interest in need, and infusing the issue of disability across the culture of CDC, and was very excited to see where this was headed.

Dr. Schneider was struck by what Dr. Boyle said about disparities for people with functional limitations, or disabilities in general—that it is not due to disability itself, but is instead due to the lack of focus on their healthcare. He requested that she expound on this intriguing comment.

Dr. Boyle responded that she was trying to say that the focus might be on a person's disability versus placing the emphasis on illness prevention and health promotion. The term for this is "diagnostic overshadowing." There needs to continue to be an appropriate focus on care of the individual's underlying disease status, but there also needs to be a focus on health promotion and disease prevention activities.

Dr. Schneider said he likes the term "syndemic" that refers to multiple levels of negative social determinates of health that affect health outcomes. In terms of some of the data presented, it was clear than when minority status was layered in various ways on top of disability, health outcomes were even worse. He wondered if there was enough information to confirm that.

Dr. Krahn replied that taking it the other way and starting by factoring out some of the other health determinates like poverty and race / ethnicity, there are times where the disability itself does not account for much after that. One of the issues that often arises regards how to know



whether the disability is contributing to the negative effect, like obesity or smoking. Short of longitudinal studies that everybody would love to have, there are ways to assess the data. A very high rate of smoking is observed in younger cohorts that are not believed to have led to their disability identification, so it is not believed that smoking led to the disability. Children with diagnosed conditions are also at higher risk for obesity than are children without that kind of condition. While it is known that sometimes obesity leads to mobility limitation and/or diabetes, it is not the only pathway.

Dr. Ross emphasized that it is known that ostracization and isolation lead to increased stress and predilection for rare diseases and unhealthy behavior, and so it certainly seems quite relevant that there should be an equal focus on workforce discrimination. That is of particular interest, but may be outside the purview of NCBDDD or even CDC. He had difficulty disentangling that element of high stress, and the heightened sense of being isolated. He wondered what NCBDDD had done to advocate for improved workforce inclusion.

Dr. Boyle replied that this is an initiative that has been supported by the Office of the Director, and Dr. Campbell is serving on the across CIO workgroup as mentioned. It would be beneficial to have a “stamp of approval” from HDS and OMHHE, which would put their power behind the initiative. Making this known to the director would be very helpful. They have been told by their health communication authorities that something must be heard three times before it is learned. There are many priorities at CDC and it is a very complex world and complex time. As mentioned, NCBDDD is a small program, and this activity falls within a branch, in a division, in a small center. Whatever HDS and OMHHE can do to give them some leverage would be terrific.

NCBDDD is working on the concept for an issue of *CDC VitalSigns™* that would focus on disability and asking a person to grade their health. Obviously, people who have disabilities are much more likely to report having poor health. While there are pathways to that, they cannot be illustrated and that tends to help reinforce that poor health equals disability. They would like to arrive at a day when the *MMWR* includes a descriptive table with disability status as a routinely recognized descriptive variable.

Dr. Campbell added that in the *2011 CDC Health Disparities and Inequalities Report*, disability was included by design. However, 17 of the 33 tables did not have disability broken out in a meaningful way. It was broken out 17 different ways. It is important to convince investigators to report disability as a stratification variable in their tables.

Dr. Rimmer emphasized that the HDS recommendations should be inclusive of people with disabilities. When there is discussion of issues like promoting a dual approach to implementing universal interventions and targeted community and clinical interventions, those interventions must be inclusive of people with disabilities. What is often seen in the disability community is a lack of representation when recommendations are being developed.



Connecting with the HHS Office of Minority Health Advisory Committee

Dr. Ro reminded everyone that she currently chairs the HHS Advisory Committee on Minority Health (ACMH). ACMH meets quarterly and includes representatives from all racial and ethnic groups. ACMH's charter directs them to develop recommendations to the Deputy Assistant Secretary for Minority Health. Given that the HHS Office of Minority Health helps facilitate and coordinate across the various agencies' Offices of Minority Health, it has been deemed within the purview of ACMH to make recommendations as such. Over time, ACMH has developed various sets of recommendations. One recommendation focused particularly on minorities with disabilities. She offered to share this information with HDS if they are interested in developing a set of recommendations to move forward. ACMH has also tackled the issue of infant mortality, with an initial set of recommendations pertaining to outreach and enrollment. In May 2013, ACMH plans to consider the issue of customer assistance and patient protection from an Office of Civil Rights approach, because there are concerns that despite the good and well intentioned efforts be the national, state, and local levels, resources are typically insufficient to address these issues. Trying to get the most people covered does not necessarily mean focusing on communities of color or other vulnerable populations. ACMH is very concerned with LGBT communities, as well as the disabilities population. Integrating and embedding health equity as an organizational approach and into systems is critical to changing the culture of how this work is done. How often do you change how you work? How else can you make sure you engage communities. How can you make sure you hear the voices of those communities? During ACMH meetings, panels are created that include HHS representatives and community members so that the dialogue can occur between them in-person. When developing recommendations, the ACMH assesses what other agencies are doing, and submits its recommendations to agencies such as CDC, HRSA, CMS, et cetera for review.

Discussion Points

Dr. Liburd acknowledged HDS's awareness of the numerous advisory committees and workgroups, and hopes to reach out to those committees and better understand their specific agency, issues, and gaps. For instance, one of the issues they observed with the Secretary's Advisory Committee on Infant Mortality (SACIM), which recently has been working on a national agenda to address infant mortality, is that there was not a health equity or health disparities lens on those recommendations. That is highly distressing given the populations that are affected by infant mortality. In that case, a very specific recommendation was made for Dr. Gracia to recognize that a health equity lens was absolutely critical to move a national agenda forward. ACMH should be made aware of anything that HDS could leverage or would want to raise up, and SACIM is happy to ensure that HDS is well aware of its work. A concern of the ACMH is the success of the Offices of Minority Health in general and in light of sequestration. A path to making sure that these offices are impactful is a role that the advisory committee takes very seriously in terms of support and recommendations regarding funding, support, and infrastructure.

Dr. Schneider inquired as to how many agencies within HHS have Offices of Minority Health and Health Equity, and he wondered whether there was a reporting structure through advisory committees such as HDS. It seemed to him that in terms of coordination and not duplicating efforts, it would make sense to have a reporting structure for these advisory committees so that there is a department-wide sense of what is occurring across agencies.



Dr. Ro replied that there are currently offices in six agencies: CDC, AHRQ, SAMSHA, FDA, CMS, and HRSA). Some agencies or offices, such as the Administration on Children and Families (ACF) do not currently have an Office of Minority Health and Health Equity. In terms of a reporting structure, the HHS Office of Minority Health also leads and coordinates the Federal Interagency Health Equity Team (FIHET). It is through that FIHET structure that the Offices of Minority Health and Health Equity are integrated and coordinated. The overarching plan is the HHS Health Disparities Action Plan. In addition to that is the National Stakeholder Strategy for Achieving Health Equity, which is based on the National Partnership for Action. There are multiple agendas running, and one of the major challenges regards coordination, function, and figuring out how it all weaves together.

Dr. Liburd sees some of the memos from the advisory committee to Dr. Koh, and from Dr. Koh to the Secretary. She wondered how helpful the Secretary is through this process in terms of supporting the work of the Office of Minority Health.

Dr. Ro responded that the ACMH works very closely with Dr. Gracia to be supporting of the Office of Minority Health and ensure that there is some alignment, and to raise emerging issues that may not have visibility. For instance, the ACMH has sent memos forward on foster children because they have no visibility. Dr. Koh has been very supportive of the ACMH and has asked the committee in some cases to address specific issues, such as the quality of public health measures and metrics, and to embed that in the committee's work going forward. The ACMH also attempts to ensure that the health disparities data being produced gets some visibility. The committee engages in a lot of outreach, especially to make sure that there is a public presence at the ACMH meetings, and to give Dr. Gracia some leverage to indicate that not only did the committee members attend, but also there was a large audience who were very interested in the ACMH's deliberations. It has made an impact, and certainly allowed her to bring forward the ACMH's recommendations with some weight.



Critical Issues Going Forward: Brainstorming Session

During this session, the members deliberated how the committee should move forward in terms of what they would like to accomplish, how to set priorities, and how to organize themselves for this work. Dr. Richardson led the group through a brainstorming exercise to think about these issues. The group initially developed a list of 17 topics of interest/importance. They then voted on which of those to prioritize first, and subsequently settled on a list of 5 topics. The initial list is presented in the order it was called out, with the main points captured under their respective topics:

1. Formal subcommittee recommendation to the CDC Director:
 - The new templated language for the FOAs should include some conversation about health equity and should require evaluation of the impact of that on actual products
 - In terms of the current recommendations Dr. Richardson will be submitting during the ACD meeting, the ACD will review the recommendations and may request further information or offer additional input or decide to move them forward as they are
2. Health Disparities Subcommittee workgroups need to be assessed:
 - The IOM Recommendation Workgroup completed its task
 - Consider establishing a White Paper workgroup
 - Perhaps an Information Coordination Workgroup is needed
3. CDC has decided to discontinue the REACH Program:
 - It is unclear how this work will continue with the loss of this program
 - Perhaps HDS should address this
 - During the final selection process, it was decided that HDS would craft a specific statement for Dr. Richardson to present to the ACD
4. HDS administration:
 - How to work
 - Meeting frequency
 - Meeting format
 - Would like to convene an in-person meeting in October in order to coincide with the State of Health Equity Forum and the Sencer Museum exhibit.
5. Coordination of information across various organizations is critical:
 - The IOM recently charged a new committee, the Population Health Roundtable, whose work correlates significantly with HDS's work; follow up with IOM staff to clarify their charge
 - Drs. Ross and Liburd had an opportunity to draft a high level White Paper that is suitable for publication that addresses some of the core issues regarding how to promote or embrace social determinants of health through educating public health students and the established public health workforce
6. Influence/inform public health training and composition in terms of health equity and SDOH workforce diversity:
 - This pertains to students and the current workforce



7. Inform accreditation via the Public Health Accreditation Board (PHAB):
 - HDS should consider embracing this as a joint project
 - There is a timeliness issue involved with this because the opportunity to do this is now, but it may not be feasible
8. Forum on the State of Health Equity at CDC:
 - As noted earlier, determine whether HDS can meet in-person in October in order to coincide with the State of Health Equity meeting
 - Determine how HDS might be supportive of this effort
 - Unanimous consensus that this effort should be supported, and that an effort should be made to coincide the HDS meeting to be in-person in October; no votes were required on this topic
9. Prevention in Public Health Fund (PPHF):
 - Ensure that work in the PPHF has a health equity lens either by HDS making recommendations through ACD or calling for accountability and health equity in the plans that are developed
 - HDS should have an opportunity to hear about the programming that is being done with these funds, and to offer input in the planning stages
 - Offer some specificity about these funds regarding priorities, money, and incorporation of a health equity lens
 - Half of the PPHF funds are being allocated to CMS this year for the Health Insurance Exchanges
 - It is not clear whether this is an actionable item
10. Preparedness and disaster response:
 - This offers an opportunity to highlight the extreme effects on communities at higher risk for disparities, as well as an opportunity to change the way in which work is done with communities at higher risk
 - Ensure that these efforts also have a health equity lens, and offer concrete examples of the health equity / disparities focus as it pertains to resilience and recovery
 - Preparedness does an excellent job of community engagement and language access, but that is where it stops
11. Language for health equity in RFAs:
 - A template has been developed
 - About 15 FOAs have been published using the new template, which includes a section on clarifying target populations and the importance of inclusion
 - Guidance is being developed for all of CDC's CIOs regarding how to design their announcements to more aggressively address health equity; there has been some pushback and a request for more specific indicators across all health areas
 - Invite FOA Workgroup members to present to the subcommittee



12. Assessment of communities of people at the highest risk for the greatest health disparities:
 - Based on the assessment, rank to determine priorities
 - There is a way to rank communities that are at the highest risk in order to gain some perspective on the specificity or order or specificity of recommendations
13. Leverage HDS's ability to make an impact:
 - Endorse existing recommendations or standards
14. Language access and cultural competency:
 - CDC plays a major role in terms of health education for the nation on any number of issues
 - Language access and cultural competency must truly cut across all communities
 - In the new insurance market places, Health Insurance Exchanges will be offered only in English and Spanish—that is only two languages; CDC will be pushing forward as a whole on that issue in terms of health equity is critically important
 - A compilation of the status of programs will be done over the next few months
 - Have a workgroup formed and ready to deliberate what recommendations should be made based on that assessment
15. Emergent or acute opportunities:
 - In terms of collecting data on gun violence, there is strong need for public support; Dr. Richardson will raise this issue during the ACD meeting
 - HDS could make a statement about why health equity is an important feature
16. Assessment of the *Community Guide* for health equity in the way that NCBDDD did for disabilities:
 - Invite a representative from the *Community Guide* to make a presentation to the HDS
17. Provide reaction / response to the CHDIR:
 - This is due to be published in the fall of 2013, so this would have to be done fairly rapidly

In recognition of the fact that each of these suggestions would require significant work, and that they had enumerated more work than this group could accomplish in two to three years on the board, Dr. Richardson led the group in a prioritization exercise. She suggested that they try to identify two to three priorities and develop a plan to begin work on those. The goal was not necessarily to abandon the other suggestions, but was simply to make some determination of what to work on next. She reminded everyone that some of the suggestions were time-sensitive. For example, the CHDIR report is very time-sensitive because it is only a few months from publication, and they are already making plans for the 2015 version. The gun violence issue is also very timely, and HDS could probably craft a relatively cogent statement that might find easy support at the ACD level. She also noted that some of the suggestions were similar and could be collapsed together. At this time, everyone was allotted three votes and articulated their choices. The five selected categories were framed 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
 - 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 workgroup 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
 - 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



Dr. Richardson observed that considerable progress would have to be made on tasks 1, 4, and 9 due to the timeframes, and that sufficient progress should be made on them by the fall. They could then turn their attention to tasks 2 and 5. Consideration must also be given to what type of staff support would be needed/available. They must also keep in mind that they may have some additional work to do based upon the feedback received from the ACD regarding the current recommendations. Workgroups are likely to be needed to address the priorities, so Dr. Richardson requested that members send an email indicating the workgroup on which they would be interested in participating. Forming working groups would pose less of a challenge, given that this would not involve the same requirements to post a notice in the *Federal Register*, achieve a quorum, et cetera. A considerable amount of work can be accomplished in working groups without a quorum, and then the information can be submitted to the full committee for any voting decisions necessary. The first working group call will focus on CHDIR and the FOA template, and may include other issues as well. Convening a series of workgroup calls should help to further flesh out these priorities.



Public Comment Period

No public comments were offered during this meeting.

Wrap Up / Adjournment

Dr. Richardson recognized and expressed appreciation for several members of the HDS who were rotating off of the committee, including: Drs. Phillip Bowman and Jason Schneider who were present, Dr. James Rimmer who was in attendance via teleconference, and Drs. Elena Rios and Fleda Jackson who were not able to attend. She requested suggestions via email to her or Dr. Liburd regarding potential nominees to replace the departing members.

There was consensus among the HDS members that they would like to have an in-person meeting in October 2013 that coincides with the State of Health Equity Forum. Perhaps a teleconference can be convened in August 2013 to form the agenda for the October meeting. This will be taken into consideration in terms of alignment with the ACD meeting, *Federal Register* notice, and budgeting issues. Committee members will be informed of the findings about being able to have an in-person meeting in October as soon as possible.

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



Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 24, 2013, 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:

Bowman, Phillip, PhD

Director and Professor Diversity Issues in Health Disparities Initiative
National Center for Institutional Diversity
The University of Michigan

Duran, Bonnie M., MPH, DrPH

Associate Professor, Health Services
University of Washington
(via teleconference)

Mullen, Jewel M., MD, MPH, MA

Commissioner and State Health Officer
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

Rimmer, James, PhD

Professor and Director, Lakeshore Foundation/UAB Research Collaborative
School of Health Professions, University of Alabama

Rios, Elena, MD, MSPH

National Hispanic Medical Association
(via teleconference)

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.



Schneider, Jason, MD
Immediate Past President
Gay and Lesbian Medical Association

CDC Staff Present:

Botchwey, Nisha, PhD, MCRP, MPH
Associate Professor
Georgia Institute of Technology

Boyle, Coleen
Director
National Center on Birth Defects and Developmental Disabilities

Campbell, Vince, PhD
Senior Health Scientist, CDC Chief Disability Officer
National Center on Birth Defects & Developmental Disabilities

Hall, Mary E.
Public Health Analyst
Office of Minority Health and Health Equity

Hickman, Gayle J.
Committee Management Specialist, ACD
Advance Team, Office of the Chief of Staff

Hutchins, Sonja S., MD, PhD, MPH
Medical Epidemiologist
Office of Minority Health and Health Equity

Kauffman, Rachel
Epidemiology and Analysis Program Office
Office of Surveillance, Epidemiology, and Laboratory Services

Krahn, Gloria, PhD, MPH
Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities

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

Luster, Adrian
Team Lead
Office of Noncommunicable Diseases, Injury, and Environmental Health
National Center for Chronic Disease Prevention and Health Promotion



Molina, Monica

Office of Minority Health and Health Equity

Yoon, Paula, ScD, MPH

Epidemiology and Analysis Program Office
Office of Surveillance, Epidemiology, and Laboratory Services

Taillepierre, Julio Dient, MS

Team Leader, Initiatives & Partnerships Team
Office of Minority Health & Health Equity

General Public Present:

Gonzalez, Sarah

Medical & Scientific Writer/Editor
Cambridge Communications & Training Institute
(via teleconference)

Wallace, Stephanie

Medical & Scientific Writer/Editor
Cambridge Communications & Training Institute



Attachment #2: Acronyms Used in this Document

Acronym	Expansion
ACA	Affordable Care Act
ACD	Advisory Committee to the Director
ACF	Administration on Children and Families
ACMH	HHS Advisory Committee on Minority Health
ADP	Office of the Associate Director for Policy
ACS	American Community Survey
AHRQ	Agency for Healthcare Research and Quality's
AHS	American Housing Survey
ADA	Americans with Disabilities Act
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHANGE	Community Health Assessment aNd Group Evaluation
CHDIR	CDC Health Disparities and Inequities Report
CHIS	California Health Interview Survey
CHNA	Community Health Needs Assessment
CHNA	Community Health Network Area
CMS	Centers for Medicare & Medicaid Services
CTG	Community Transformation Grants
CUPS	CDC Undergraduate Public Health Scholars (CUPS)
EHDI	Early Hearing Detection Intervention Team
EHRs	Electronic Health Records
EPA	Environmental Protection Agency
FDA	Food and Drug Administration
FIHET	Federal Interagency Health Equity Team
FOA	Funding Opportunity Announcement
HCDI	Healthy Community Design Initiative
HDS	Health Disparities Subcommittee
HHS	(United States Department of) Health and Human Services
HIEs	Health Information Exchanges
HP	Healthy People
HRSA	Health Resources and Services Administration
HUD	(United States Department of) Housing and Urban Development
ICF	International Classification of Functioning, Disability and Health
IHME	Institute for Health Metrics and Evaluation
IOM	Institute of Medicine
LGBT	Lesbian, Gay, Bisexual, and Transgender Community
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
NIH	National Institutes of Health
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion



Acronym	Expansion
NCEH	National Center for Environmental Health
NCHS	National Center for Health Statistics
NHIS	National Health Interview Survey
NPHII	National Public Health Improvement Initiative
OD	Office of the Director
OMHHE	Office of Minority Health and Health Equity
REACH	Racial and Ethnic Approaches to Community Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SACIM	Secretary's Advisory Committee on Infant Mortality
SMEs	Subject Matter Experts (SMEs)
US	United States
WHO	World Health Organization
USDA	United States Department of Agriculture

