

## Meeting Summary

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

Friday, August 9, 2013  
8:30 am– 4:00 pm (EDT)

**Objective:** Provide update on CDC and OSTLTS priorities and progress completed towards ACD-adopted recommendations from the STLT Workgroup

**Chairperson:** David Fleming, MD

**Designated Federal Official:** Judith A. Monroe, MD

**Prepared by the Office for State, Tribal, Local and Territorial Support (OSTLTS)**

**STLT Subcommittee Members Present:** David Fleming (Chairperson), John Auerbach, Dileep Bal, Terry Cline, Bruce Dart, Jonathan Fielding, James Gillan, David Lakey, Carol Moerhle, Lillian Rivera, Mary Selecky, Jewel Mullen (teleconference)

**Presenters:** Judy Monroe (DFO, CDC), Robin Ikeda (CDC), Laura Seeff (CDC), Denise Koo (CDC), Laura Conn (CDC), Pamela Diaz (CDC)

**Others Present:** Shauna Mettee, Akshara Menon, Aila Moss, Duiona Baker, Jim Galloway, Stacy Mattison, Craig Thomas, Justin Davis, Katie Verlander, Harold Pietz, Charlotte Kent, Andrea Young, Chesley Richards, John Douglas, Stuart Berman, Frederic Shaw, Matthew Penn, Liza Corso, Kathleen Ethier, Lorine Spencer, Robin Moseley, Kate Agin, Joel Stanojevich, Danielle Hildebrand, Paul Stange, Akaki Lekichvili, Judy Lipshutz

**Notes:** Judy Kuo (CDC Contractor)

**I. Welcome/Call to Order**

David Fleming welcomed the STLT Subcommittee members and reviewed implications of their movement from a workgroup to a subcommittee. Recognizing the significant importance of having input from STLT agencies to the business of CDC, the STLT Workgroup now has been established as Subcommittee falling under the Federal Advisory Committee (FACA) regulations. As a FACA, meetings are now subject to several protocols:

- Meetings are announced in the Federal Register
- Meetings are open to the public
- A public comment period is incorporated into each meeting agenda
- The committee must meet the quorum of nine members to proceed forward with meetings

**II. Introductions**

All members introduced themselves and disclosed any conflicts of interest. DOH-Miami-Dade

Subcommittee Member	Title and Organization	Conflict of Interest Disclosure
Lillian Rivera	<ul style="list-style-type: none"> <li>• Administrator, Miami-Dade County in Florida Department of Health in Miami-Dade County (DOH-Miami-Dade)</li> </ul>	DOH-Miami-Dade receives both direct funding and funding through the state health department from CDC.
John Auerbach	<ul style="list-style-type: none"> <li>• Director of Institute on Urban Health Research and Practice at Northeastern University</li> <li>• Past President, Association of State and Territorial Health Officials (ASTHO)</li> <li>• Former Commissioner, Public Health for the Commonwealth of Massachusetts</li> </ul>	The Institute of Urban Health Research and Practice applies for and receives grants from CDC.
Jonathan Fielding	<ul style="list-style-type: none"> <li>• Director, Los Angeles County Department of Public Health</li> <li>• Los Angeles County Health Officer</li> <li>• Professor in the Schools of Medicine and Public Health at the University of California – Los Angeles (UCLA)</li> </ul>	The Los Angeles County Department of Public Health and UCLA receive funds and grants from CDC.
David Lakey	<ul style="list-style-type: none"> <li>• Commissioner at the Texas Department of State Health Services</li> <li>• Past President of ASTHO</li> </ul>	The Texas Department and ASTHO receive funds from CDC.
Mary Selecky	<ul style="list-style-type: none"> <li>• Secretary (retired) of the Washington State Department of Health</li> <li>• Independent Consultant</li> </ul>	The Washington State Department of Health receives funds from CDC.
Bruce Dart	<ul style="list-style-type: none"> <li>• Director of the Tulsa Health Department in Oklahoma</li> </ul>	The Tulsa Health Department receives funds from CDC.
Carol Moehrle	<ul style="list-style-type: none"> <li>• District Director of Public Health – Idaho North Central District</li> <li>• Chair for the Public Health Accreditation Board (PHAB)</li> </ul>	The Idaho North Central District receives funds from CDC through the state department. PHA B receives funds from CDC.

Subcommittee Member	Title and Organization	Conflict of Interest Disclosure
Terry Cline	<ul style="list-style-type: none"> <li>• Oklahoma Secretary of Health and Human Services</li> <li>• Commissioner of the Oklahoma State Department of Health</li> <li>• President-elect for ASTHO</li> </ul>	The Oklahoma State Department of Health receives funds from CDC.
James Gillan	<ul style="list-style-type: none"> <li>• Director, Guam Department of Public Health and Social Services</li> <li>• ASTHO Board Member</li> </ul>	The Guam Department of Public Health and Social Services receives funds from CDC.
Jewel Mullen	<ul style="list-style-type: none"> <li>• Commissioner, Connecticut Department of Public Health</li> <li>• ASTHO Board Member</li> </ul>	The Connecticut Department of Public Health receives grants from CDC.
Dileep Bal	<ul style="list-style-type: none"> <li>• Health Officer, Kauai District, Hawaii</li> </ul>	The Kauai District receives CDC funding through the state of Hawaii
David Fleming (Chair)	<ul style="list-style-type: none"> <li>• Director and Health Officer, Public Health, Seattle and King County</li> </ul>	Seattle/King County Public Health receives funds from CDC

**III. Meeting Objectives**

The objectives for this meeting were as follows:

- Review CDC progress on the 12 recommendations related to the health department of the future that were adopted by the ACD as put forth by the STLT Subcommittee
- Review changing landscape of public health and how it fits into the larger health system
- Refine recommendations, as appropriate, based on changes since recommendations were adopted in October 2012
- Review OSTLTS relevant activities and provide feedback/guidance as appropriate

**IV. Overview of CDC Updates**

Dr. Judy Monroe highlighted an article, “Health Departments in a Brave New World” by Christopher Maylahn, David Fleming, and Guthrie Birkhead.<sup>1</sup> This article outlined the need for health departments to focus on chronic disease, improve surveillance on chronic disease, and enhance evidence-based decision-making.

CDC Strategic Directions

Dr. Monroe provided an overview on CDC activities, budget, and challenges facing the agency. She described the three priority strategic directions for the agency:

- 1) Improve health security at home and around the world
- 2) Better prevent the leading causes of illness, injury, disability, and death
- 3) Strengthen public health – health care collaboration

The first strategic direction focuses on detecting threats early through surveillance systems and addressing workforce needs; responding effectively through enhancing surveillance technology; and preventing avoidable catastrophes. Six key winnable public health battles were identified to address the second strategic direction regarding preventing the leading causes of death. These winnable areas are: tobacco; nutrition, physical activity, obesity and food safety; healthcare-associated infections; motor

<sup>1</sup> Maylahn C, Fleming D, Birkhead G. Health departments in a brave New World. Prev Chronic Dis. 2013 Mar;10:E41.

vehicle injuries; teen pregnancy; and HIV. As a nation, various levels of progress have been made around each winnable battle. For the third strategic direction, several activities address strengthening linkage between public health and health care, including, for example, the expansion of Medicaid, ACA provisions for clinical preventive services, and community health improvement initiatives (e.g., community health needs assessments, Community Transformation Grants, etc.)

### Lessons Learned

CDC is learning lessons as it moves work into the evolving health systems environment. John Auerbach provides observations in his recent article<sup>2</sup> reflecting experiences in MA that can be considered in the work before CDC:

- Get a seat at the table
- Take an open-minded and critical look at the work public health does now
- Defend the traditional public health approach when called for
- Keep on the lookout for opportunities
- Envision a better model and take steps to make it real

### CDC Budget

Dr. Monroe provided an overview of the cost breakdown for CDC-funded activities. Key points:

- There will be a 5% or \$285 million cut to the FY2013 budget.
- FY2013 budget is almost \$600 million below the FY2012 budget.
- The majority of CDC funding goes to state and local government so the budget changes will have an impact on core public health services across the US.

### OSTLTS Update

- OSTLTS is in its second year of the National Leadership Academy for the Public's Health (NLAPH). NLAPH trains teams of community stakeholders who work on an agreed-upon project in their community. In addition to public health leaders, leaders from multiple sectors (e.g., city planners, architects, representative for the mayor's office, public health leaders) who can impact the project are provided training to develop skills and expertise to complete the project. NLAPH aims to develop leadership skills through the experience of addressing a community issue. Alumnae of NLAPH serve as coaches for these teams and share best practices and lessons learned. Community Transformation Grant (CTG) grantees are among those who have completed this training.
- OSTLTS has been providing technical assistance for the State Innovation Model award (SIM) state grantees. OSTLTS reached out to the state health officials (SHOs) whose states have received a SIM award and collaborated with the National Governor Association (NGA), CDC's Office of the Associate Director for Policy and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to support and assist the SHOs to become involved in the SIMs efforts.

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<sup>2</sup> Auerbach J. Lessons from the front line: The Massachusetts experience of the role of public health in health care reform. Public Health Manag Pract. 2013 Sep-Oct;19(5):488-91.

## STLT Subcommittee: Meeting Notes

- The Public Health Associate Program (PHAP) has seen significant growth since 2007. The aspirational goal is to have 200 trainees each year. Associates are currently assigned to 34 states, two tribes, one territory, and the District of Columbia.
- The Public Health Prevention Service program focuses on providing field-based assignees to state, tribal, local, and territorial health departments. Only three states have not had an assignee in the duration of this program.
- OSTLTS is reviewing ways to align PHAP and PHPS so as to achieve more efficiencies and ensure the training is meeting the needs of public health for the future

### Challenge for the STLT Subcommittee Meeting

Dr. Monroe challenged the STLT Subcommittee to keep in the mind the following questions as the meeting and discussion progress throughout the day:

- Is CDC responding to recommendations as needed?
- Do recommendations need refinement?
- Would new recommendations be useful?
- With the expanding set of players, how can CDC ensure efforts add value and are not duplicative of others?

### **V. Committee Report/Discussion: Core Services**

Dr. Robin Ikeda provided an update on the progress completed towards the recommendations related to core services:

- Recommendation #1: CDC should gather and analyze information from STLT partners regarding the current practice and thinking regarding core public health services.
- Recommendation #2: CDC should create a stakeholder process to provide guidance to CDC and STLT health departments facing decision-making about future services and programs.

### Progress for Recommendation #1

- CDC reviewed multiple sources for activity and publications on core public health services. These sources included the Institute of Medicine (IOM), Trust for America's Health (TFAH), Robert Wood Johnson Foundation (RWFJ), Association of State and Territorial Health Officials (ASTHO), and the National Association of County and City Health Officials (NACCHO). A lot of overlap was found in how core services were addressed, but these sources served to begin movement toward consensus from different sources about what is meant by core services.
- CDC is considering featuring state activities on core public health services through CDC public channels, such as the STLT Gateway.
- Discussions are ongoing about the standardization of terminology for what is meant by "core services." For now, the CDC working group has settled on using, "minimum package of public health services," which includes both foundational capabilities and basic services. This language comes from the IOM report "For the Public's Health: Investing in a Healthier Future."
- Work continues in collaboration with CDC's Public Health Law Program (PHLP) which has begun an assessment of State enabling authorities to determine whether state laws contain or reference a set of fundamental activities for state/local public health agencies (e.g., core services, 10 Essential Services)
  - ✓ Preliminary findings indicate that a subset of states (15/51) incorporate concept of a fundamental set of activities for public health agencies mostly referencing the term: *ten essential public health services*.
  - ✓ Other laws reference what is funded and accreditation

- ✓ In Phase 2 of this effort, PHLP plans to further explore what states mean by their enabling authorities and whether they reference a set of fundamental activities for state/local public health agencies by other names not found in the first assessment

### Progress for Recommendation #2

- RWJF through RESOLVE is convening a multi-phase stakeholder process to build a consensus around a model for the minimum package of services. CDC will participate in this effort rather than develop a separate process, as originally proposed by the ACD. In Phase II of this effort, CDC will play a leadership role in the communications plan, especially in communicating with STLTs.
- RWJF expects a draft report on this model will be completed and available for vetting by the end of the year.

### Identified Challenges and Opportunities

- Opportunity – Explore inclusion in CDC FOA redesigned template to include language that allows support of core public health services (like language for meeting PHAB accreditation standards)
- Challenge -- Even with the consensus models that grow out of RESOLVE effort, there may remain gaps as well as implications for existing funding streams and sources.

### Discussion

- Recommendation was made to revisit the terminology for the core set of public health services. The term “minimal” may give the perception that other services may not have been included in the set. The term “foundational” has a more positive perception though may not be all inclusive of what is “core.”
- It is hoped that the stakeholder process will provide greater specificity around the core set of service for public health, information regarding the cost and financing of those services, and how these services are tied in with accreditation.
- CDC will need to continue to consider the external factors that impact the core services. These external factors include the implementation of the ACA and stakeholder and partner perceptions.
- When talking about core services, social determinants are an important factor to incorporate into recommendations and activities.
- CDC should ensure that core services are not perceived as equal to “meeting accreditation standards” (a more extensive process). Rather, ensuring core services can help serve to begin preparing for accreditation. The relationship between these two issues should be clear and not confounded by each other. Accreditation is voluntary whereas the idea of core services has to do with ensuring the availability of certain services to all populations (which shouldn’t be “voluntary”).

## **VI. Committee Report/Discussion: Financing**

Dr. Laura Seeff provided an update on the progress completed towards the recommendation related to financing:

- Recommendation: CDC should collaborate with the Health Resources and Services Administration (HRSA), CMS, and private insurance to develop strategies that support financing for population health, and encourage and support collaboration between public health and clinical medicine in the development of Accountable Care Organizations (ACOs).

### Progress for Recommendation

- CDC continues to strengthen its relationship with the Center for Medicare and Medicaid Innovation (CMMI). CDC co-leads the Million Hearts Initiative and has provided support in the design and development of the new Health Care Innovation Awards (HCIA) Round Two.
- CDC has been integral in helping to engage state health officers in SIMs states planning efforts where financing issues are central
- CDC also continues to engage with external groups around financing. These external groups include efforts such as the IOM Population Health Roundtable, ASTHO Resources Committee, the American Public Health Association (APHA), and the RWJF-supported Chart of Accounts activities.

### Identified Challenges and Opportunities

- Challenge: Since the field is rapidly evolving, the financing recommendation approved in October 2012 may need updating.
- Opportunity: CDC is suggesting to the STLT Subcommittee to expand the financing recommendations to focus on two broad questions
  - What is the role of CDC in development and testing of financing models that ensure coverage of population health and inclusion of preventive services?
  - How can CDC best ensure support for foundational capabilities of health agencies including their function as the community's safety net provider?

### Discussion

- Public health has made an impact in policy changes in the health care sector. However, in order to achieve population health outcomes, healthcare and public health need to be incorporated into all aspects of the general plan in a city/community/state. In order to get public health a seat at the table, public health needs to develop more expertise on the broader issues of health, not just financing.
- To achieve a balanced portfolio, integration of clinical and public health as well as community-based services needs to incorporate an infrastructure that includes upstream determinants.
- There is a general consensus that ensuring financing for population health is a timely and critical issue. To identify all effective strategies, collaboration with public health needs to be broadened across different sectors and inclusive of multiple stakeholders.
- CDC can collaborate not only with federal agencies, but can also provide collaboration assistance at the state level. The SIM model can be utilized as the framework to reach out to all sectors through the Governors' offices.
- One concern is that states may not have necessary expertise on financing public health and do not understand existing models. CDC can provide guidance or prescriptive advice to states and/or distribute various models and prototypes for states to adopt and implement.
- There is a need for consistent, refined taxonomy and clarity regarding what is the return on investment (ROI) for public health. CDC can support efforts to better understand ROI for various interventions/programs/infrastructure building to help clarify that thinking.
- One of the challenges is that there are important impacts beyond medical costs.

## **VII. Committee Report/Discussion: Shared Services**

Dr. Ikeda provided an update on the progress completed towards the recommendations related to shared services:

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- Recommendation #1: CDC should establish a clearinghouse of program practices that demonstrate how shared services work in the field.
- Recommendation #2: CDC should identify ways to encourage use of shared program services including but not limited to incentives built into funding opportunity announcements (FOAs).
- Recommendation #3: CDC should continue to partner with existing efforts to promote shared services (e.g., CSPHS in Kansas and PHSSR at the University of Kentucky, others) to identify added-value opportunities for collaboration, especially related to promotion of promising practices and development of tools/technical assistance, thus encouraging their implementation and ensuring the success of these initiatives.

### Progress for Recommendation #1

- CDC is continuing to develop a “sharing services” website that will include key concepts and definitions, resources and links, information on CDC activities that promote cross jurisdictional sharing, and field experiences and stories.
- CDC continues to coordinate with the Center for Sharing Public Health Services (CSPHS) to ensure synergy of efforts.

### Progress for Recommendation #2

- Language to foster and encourage shared services has been proposed for the updated CDC FOA template.
- A CDC-wide data call was released to collect information on how the agency is encouraging cross-jurisdictional sharing (CJS). Preliminary findings include: supporting inter-state sharing of services around discrete activities or services; providing technical assistance and training; and promoting peer sharing or supporting demo site projects.

### Progress for Recommendation #3

- CDC continues to monitor state and local activities. CSPHS supported this effort and was involved in the kick-off meeting and learning community.
- Success stories have been identified and will be highlighted through CDC channels.

### Identified Challenges and Opportunities

- How strongly should CDC push the importance of shared services in the FOAs? Should this be required, incentivized, or strongly encouraged?
- Are there real or perceived legal barriers that need to be explored?

### Discussion

- Having a collection of concrete examples of cross-jurisdictional sharing (CJS) of services will be beneficial. Examples could include numerous existing cooperative agreements that encourage CJS (e.g., NPHII cooperative agreement) and the laboratory efficiency initiative. Highlighting these examples would be CDC’s role.
- One area to more fully explore the sharing of services is in locations where health departments are too small to meet the public health protection expectations (e.g., core services).
- There is consensus that CDC should do more in their FOAs to encourage shared services; however, this should not be the only focus. More focus needs to be put on how to improve the efficiency of using public health funding. The issue may be around capacity – there could be a mismatch of what health departments can really do versus the requirements and expectations.

- It is important to define the principles and/or criteria for why public health should share services. Initially the reasoning was budget related; however, it is important now to highlight the value of the services rather than just a cost-cutting mechanism.

### **VIII. Community Report/Discussion: CHNA/Community Benefit**

Dr. Seeff provided an update on the progress completed towards the recommendation related to community health needs assessment and community benefit:

- Recommendation #1: To ensure maximal community benefit, CDC should:
  - a) Continue to work with the IRS to strengthen the requirements for hospitals to work with health departments, and
  - b) Provide guidance to STLT health departments that will enable them to demonstrate their added value in helping hospitals meet IRS-mandated corporate compliance requirements regarding community health needs assessment and implementation strategies.

#### Progress for Recommendation #1(a)

To date, CDC has

- Assembled an actively engaged cross-agency work group focused on CHNA/CHA/CHIP
- Developed (and still developing) web resources (e.g., <http://www.cdc.gov/policy/chna/>; <http://assessment.communitycommons.org/CHNA>)
- Developed (via OSELS): “Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants”

#### Progress for Recommendation #1(b)

- Supported development of public health organizations’ consensus statement in March 2012
- Provided language to IRS for proposed rule regarding public health role
- Continue to strive towards coordinated approach for technical assistance in areas such as:
  - Strengthening awareness of connections/opportunities among hospital, HD accreditation, and grant requirements (e.g., CTG, NPHII)
  - Implementation of CHNA and improvement plan (e.g. , CTG)
  - Use of data, measures, and evaluation to improve population health
- Developed “[Principles to Consider for the Implementation of a Community Health Needs Assessment Process](#)” (Rosenbaum):
  1. Maximum transparency to improve community engagement and accountability.
  2. Multi-sector collaborations that support shared ownership of all phases of community health improvement.
  3. Proactive, broad, and diverse community engagement.
  4. Definition of community (broad while addressing disparities.)
  5. Use of the highest quality data pooled from diverse public and private sources.
  6. Use of evidence-based interventions and innovative practices with evaluation.
  7. Evaluation to inform a continuous improvement process.

#### Identified Challenges and Opportunities

- Context of CHNA can impact ability to have high impact
- Need for standard taxonomy (e.g. CHNA, CHA, CHIP)
- Need for continued provision of coordinated TA to communities
- Need for increased attention on measures, data pooling and sharing
- Need for continued interface with external groups/activities

- ACF/Community Action Agencies
- Federal Reserve/Community Reinvestment Act
- Need for continued leveraging of connections with accreditation, state law and other CHNA requirements
- Opportunity to learn from application of IRS rules for current year to prepare for 2015
- Opportunity to leverage “Principles to Consider for the Implementation of a Community Health Needs Assessment Process”

### Discussion

- This is a once in a lifetime opportunity. There has been consultation with local and state health agencies on data that is necessary to complete the process, but not on the realignment of resources. This is harder to achieve. The 6th principle is where this issue is embedded the most – strategic investment in community health that aligns with priority setting.
- Challenge remains that 10% of the population uses 90% of the resources
- How do we turn this model of CHNA into a reality? Need to teach the health departments that they can collaborate to expand the capacity to have a sound CHNA and benefit the community and public health goals. Health Departments should consider this involvement their responsibility regardless of the size and capacity of a health department – get local level to embrace and put all the tools in place.
- Should consider connecting with community action agencies as they are always doing community assessments around needs related to shelter, food banks, etc. and marry some of those findings with CHNA work.
- Should work with hospital associations to identify what are they doing related to CHNA. What are they telling their hospitals? CDC can work with hospital associations (national and state level) to encourage their hospitals to contact their public health departments to engage them in CHNA
- Having a collection of success stories would be incredibly useful.
  - ✓ governance models for community health
  - ✓ CHNAs on line
- Need to understand how to incentivize CHNA, including true population health outcomes that demonstrate the true value of CHNA (e.g., the benefit).
  - ✓ Such efforts have occurred before so what is different this time?
  - ✓ Must learn from our mistakes from past efforts
- We need “wholesale and retail” strategies.
  - ✓ Retail level is talking to governance at hospitals and helping them understand the importance and value to them of CHNA. Hospitals can learn that these efforts can have a financial benefit to them while benefitting the community.
  - ✓ Wholesale level
    - CDC should work with IRS directly to understand how the rules have played out and refine as necessary.
    - CDC should work with the American Hospital Association at the national and state level. AHA should help hospitals understand their involvement is good for them on a financial and PR level

### **IX. CDC Office of Public Health Scientific Standards/OPHSS (proposed) – formerly OSELS**

The new Director of OPHSS, Chesley Richards, shared some of his thinking about the new office:

- There will be a strong emphasis on creating a customer-oriented organization within OPHSS to ensure the office is providing the needed services to STLT health departments.
- Director needs to visit state and local health agencies to better understand their issues and needs directly.
- Progress on the reorganization of OSELS into OPHSS
  - A revised organizational chart has been submitted to the CDC Management Analysis and Services Office (MASO).
  - Functions of the divisions within OPHSS include: conducting surveillance and informatics (BioSense), enhancing the scientific workforce (EIS), promoting integration and efficiency across laboratory systems, and enhancing epidemiology tools (Community Guide, libraries).

#### **X. Committee Report/Discussion: Workforce Development**

Dr. Denise Koo provided an update on the progress completed towards the recommendations relate to workforce development:

- Recommendation #1: CDC should lead a coordinated effort with active engagement by external and internal partners to address vital workforce gaps.
- Recommendation #2: CDC should redesign its training programs for both internal CDC staff and external STLT workforce to include the core competencies needed in the 21st century health department.
- Recommendation #3: CDC should facilitate the ability of the public health workforce to partner with the healthcare system.
- Recommendation #4: CDC should partner with schools [and programs] of public health (SPH), the Association of Schools and Programs of Public Health (ASPPH), and the Council on Education for Public Health (CEPH) to realign public health school curricula with current health department needs.

#### Progress on Recommendation #1

- Building on the PH Workforce Summit and systems approaches to address gaps:
  - Revised the Roadmap (based on partner input, including all the CDC CIOs)
  - Partners (ASTHO/deBeaumont, APHL; OSTLTS/PHAP) used the Roadmap to frame workforce activities as a tool for communications
  - We have heard the message as a need to take a more systems approach, including people (individually targeted activities like fellowships), tools (e.g., electronic support of learning), and systems (both educational and employment systems)
- Developing standard position descriptions for four levels of career tracks in informatics for CIOs and STLT health departments to facilitate hiring and career paths (Sept 2013)
- Provided consultation to HRSA on HRSA TRAIN; formed CDC-HRSA workgroup on academic partnerships
- Participate in strengthening PHAB accreditation standard for workforce
- Participate in HHS workgroup to ensure that public health is represented in new health workforce action plan

#### Progress on Recommendation #2

- Finalized new project officer competencies; embarking on curriculum development (early 2014); launch expected in 2014
- Addressing core competencies through new PH 101s; all six modules are in pilot test phase

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- Expanding informatics training for EIS officers
- Expanding informatics training for state and local health department staff
  - Informatics Training in Place Program (I-TIPP) for existing state/local health staff
  - Applied Public Health Informatics Fellowship (APHIF) places fellows in state/local health departments

### Progress on Recommendation #3

- Launching the de Beaumont-funded Practical Playbook, an interactive tool for integrating public health and primary care (fall 2013)
- Enhancing academic partnerships to improve ability of public health and health care to improve health
  - MPH curriculum to include instruction on the role of public health in the health care system
  - AACN is publishing new curriculum standards on population health (Aug 2013)
  - AAMC is providing consultations on population health to medical education programs
- Launching project on population health milestones for residencies (Aug 2013)
- Adding to the Primary Care and Public Health Initiative (PCPHI); joining forces with the Million Hearts Initiative to pilot a residency faculty development program (Spring 2014)
- New PH-HC collaboration page on the CDC Learning Connection
- CDC Policy Office has supported GA Health Policy Institute to develop a new tool to support public health in context of health reform

### Progress for Recommendation #4

- Working with CIOs on new approaches, including use of direct assistance, for community-based assignments for public health fellows (ASPH and APTR fellows)
- Supported ASPH's efforts to establish a Blue Ribbon panel of 32 public health employers to learn about public health practice trends; information for the Framing the Future Task Force for revising the MPH requirements

### Considerations for Next Phase of Work

- Given importance of public health – health care integration what do you recommend as highest priority for workforce development in this area?
- Given state/local needs, does CDC have the appropriate mix among our fellowship programs and the appropriate balance among fellowship and other systems-based workforce development approaches?
- As we develop options for placing ASPH and APTR fellows in the field, how interested do you think STLT health departments would be in these trainees? In using DA to fund such?

### Discussion

- For consideration – outreach to schools (undergraduate level) who have public health programs. And for school who do not have public health programs, should they start something and as a school think about how they can enhance the workforce?
- Very strong support for the 101s; the 101s are going to be a need the entire public health workforce – lots of workforce only has high school education and is learning on the job. Looking for an opportunity to do some long term planning for replacing long term PH professionals. At the 101 level, trying to develop a new community health worker. They need to have some basic

101 thinking when they are dealing with communities because each one will have different culture aspects and value aspects.

- The schools that are training in public health professions, no clear way to get them more, linked to other disciplines, e.g., for joint degrees, to get more lawyers, accountants, IT folks into public health. Has there been some thinking about what those areas might be? And if there is a strategy that we might come up on to thinking about how we inter-train or the next generation of public health?
  - Softer skills are coming into more focus and in people's discussions. These are big issues that are not ton of resources. Informatics 101 and PE 101 are part of the 101 series. The deBeaumont foundation (head of foundation is an EIS alum, so familiar with public health) – they are very interested in PH infrastructure, informatics, and workforce
  - Also, can shift the models at the undergraduate level, they may learn practical ways to improve health and work together. Added a new capstone in the CDC medical student epidemiology fellowship program on how would you improve health as a doctor.
- There should be an increased focus on online learning as it may offer a more efficient approach to training.
- There are small disconnects between what the state and local agencies need and what the graduate PH programs are educating, training their students for. This is a gap that CDC can address.
- The message about health does not start with the MPH programs, but rather in early education (i.e. pre-school). Health literacy needs to start there. CDC could be the vehicle to start implementing health messages in early education.
- Financial analysis is a major gap in the skillset as this has an impact on the investments and determining the return on investments for public health. There is also a need for culture climate acclimation, as there is an issue on clash of cultures. CDC could consider including an introduction of culture to the health care system within the 101 courses. Other topics for 101s: policy, communications.
- CDC asked the STLT Subcommittee members to provide feedback on which one area within workforce should be the priority for such activities (not because other activities will be dropped, but if they were to pick a priority among all the activities, what would it be?).

#### **XI. Committee Report/Discussion: Electronic Health Records Exchange across Clinical Care and Public Health**

Dr. Pamela Diaz and Ms. Laura Conn provided an update on the progress completed towards the recommendation related to the exchange of electronic health records across clinical care and public health systems:

- CDC should work across the agency and in collaboration with key partners that can impact local level practice (e.g., Center for Medicare & Medicaid Services, hospitals, primary care providers) to build state and local health department capacity to exchange information with clinical electronic health record (EHR) systems or health information organizations/exchanges.

#### Progress for Recommendation

- CDC continues work towards incorporating EHRs in everyday public health use. A significant level of information and data exist from various sources, but the challenge is to incorporate this information into an integrated strategy on how public health conducts surveillance.
- CDC has three focus areas towards an integrated surveillance strategy

## STLT Subcommittee: Meeting Notes

- Improve Surveillance Efficiency: Surveillance systems should not be duplicative; common data and technical standards are used
- Advance EHR use: Exchange is meaningful, supports surveillance, and advances clinical decision support
- Utilize Common Platforms: Common technology platforms and shared services provide data to the right stakeholders at the right time and reduce burden on partners.
- CDC is reviewing all its programs to conduct an assessment on systems and data collection approaches in order to identify processes where the agency can become more efficient and streamline activities.
- Under a cooperative agreement, CDC is working to allow STLTs to gain access to EHRs instead of just remote data. CDC is providing guidance and recommendations for public health integration with clinical care in Stage 2 of the Meaningful Use initiative. There are more requirements for STLTs before they will be ready to exchange data; CDC is working towards implementing a coordinated approach for onboarding STLTs in understanding these requirements and readiness as it will ease the process for data exchange partners.
- Cloud technology would allow systems to share infrastructures and change the way in which information is shared with clinical care; this would reduce the burden on public health departments.
- CDC is establishing a CDC Surveillance and Biosurveillance Federal Advisory Committee in the Fall 2013. This Advisory Committee will support the National Public Health Surveillance and Biosurveillance Advisory Committee (NPHSBAC) by providing input into surveillance integration strategies and EHR and supporting response to PAHPRA, NBSB, and mandates for IT improvements in context of enhanced situation awareness.
- As EHR-related work continues and moves forward, coordination across CDC OSTLTS, OADP, and OSELS continues to ensure efforts are complementary and not duplicative.

### Considerations for Next Phase of Effort

- As noted, numerous national strategies and reports have addressed EHR/ELR
- CDC EHR-related activities are extensive; our approach is now being accelerated and refined, with a view toward better integration
- Current priority need: Identifying gaps and priorities in CDC's existing/planned approach
- A one-page summary of high-level recommendations has been provided to the STLT Subcommittee so that members can deliberate, review, and identify any gaps within the recommendations. The Subcommittee has been asked to provide any feedback on how the recommendation can be improved.

### Discussion: Subcommittee Response

- The primary reason that IT-related efforts have failed in the past is because stakeholders have viewed these efforts as technical and not seen their role in successful public health. But challenges related to these efforts are broader than technology, and relate to the commitment and understanding of public health leaders (who are not necessarily IT savvy) to make needed changes in the mechanics of making this really happen.
- A major challenge is related to data ownership. Today, the data is owned by the healthcare system. The healthcare system needs to be convinced that it is in their best interest to share data, and public health needs to better communicate the benefits.

- There is a perceived barrier that EHRs are a violation of HIPAA. CDC should dedicate resources to assess the real and perceived associated legal barriers so that there is a better understanding of that landscape.
- There needs to be better communication and alignment between the existing proprietary systems. Additionally, CDC should work towards streamlining their current [multiple] systems that conduct similar activities and surveillance.
- It is important that public health has a seat at the table in discussions and planning of specialized systems as it will increase linkage and integration within the health care system.
- Cloud technology offers a significant opportunity to offer real time data and increase efficiency, and CDC should take greater advantage of this technology.

**XII. Key Takeaways from STLT Subcommittee Members**

Subcommittee Member	Key Takeaways
Lillian Rivera	<ul style="list-style-type: none"> <li>• After January 2014, many answers to several unknowns regarding financing will become apparent after everything settles. We will need to look at the current marketplace for the states and see how states evolve, specifically in states that are more advanced in efforts and their thinking. Clarity regarding core services should become more apparent around this timeframe as well.</li> <li>• As a local health officer, there is a high level concern regarding preparedness but there is limited capacity around preparedness. Public health will lose credibility if preparedness is not handled appropriately and effectively.</li> </ul>
John Auerbach	<ul style="list-style-type: none"> <li>• OSTLTS has transformed relationships between STLT health departments and CDC. These relationships are important as public health faces budget cuts, decreasing the level of resources and capacity.</li> <li>• We should revisit the current recommendations from this subcommittee as the landscape has changed since the initial development; consider revisions, if any are needed.</li> <li>• There are several issues we should continue to consider:               <ul style="list-style-type: none"> <li>○ What should public health be doing? What are the core services of public health? Are the current efforts adequately addressing this question?</li> <li>○ How is health care landscape going to change as a result of ACA and what are the significant changes that are being made across the country?</li> <li>○ We need to define the opportunities for revenue and opportunities within the payment system.</li> </ul> </li> </ul>
Jonathan Fielding	<ul style="list-style-type: none"> <li>• There should be a greater focus on the underlying determinants – to reduce disparities, public health needs increase focus on social determinants and have relevant issues (e.g., social justice) central in discussions.</li> <li>• One of the fundamental issues public health faces is how the general population views public health. CDC and STLT health departments have a joint responsibility to change the branding and attributes associated with public health in order to solicit the support of the public and achieve the level of funding that is required for services.</li> <li>• Must ask the question: How can someone objectively know if they have enough services for core services?</li> <li>• Public health should continue to push the issues surrounding emergency preparedness in order to achieve positive support across the political</li> </ul>

Subcommittee Member	Key Takeaways
	<p>landscape.</p> <ul style="list-style-type: none"> <li>Improved communications and alignment is needed within HHS to ensure all OP/DIVs are onboard to provide the various support and expertise that exists within the Department and that they are in coordination</li> </ul>
David Lakey	<ul style="list-style-type: none"> <li>There has been a significant level of turnover in Texas (as well as other states) so it may be beneficial to re-educate STLT agencies about OSTLTS current role, activities, and progress.</li> <li>For core services, there is concern about the perception of what the ACA does versus the reality of essential services that public health has to do. If there is a perception that those core services are not as valuable, then this country would become a less healthy nation.</li> <li>The budget authority going down 18% is a concern as it significantly impacts the variety of core support that can be provided by CDC. If there is less support from the federal government, the credibility of public health may be negatively impacted</li> <li>There are disconnects between public health and the issue of substance and mental health. A better approach for synergy is needed.</li> <li>It is important that public health determines the return on investment of the support and services it provides to the nation.</li> <li>Communications and guidance should be improved on the value of shared services and why this works.</li> <li>The initial career path of many public health professionals was not in public health; it is important to understand how public health better equips these professionals to be successful in their jobs. One consideration is that individuals are trained at CDC and then brought back to the field; CDC can provide credible training.</li> </ul>
Mary Selecky	<ul style="list-style-type: none"> <li>The WA State agenda for change asks: <ul style="list-style-type: none"> <li>How does public health protect our successes?</li> <li>How does public health take on new challenges?</li> <li>How does public health conduct business differently?</li> </ul> </li> <li>The work that is currently being done addresses these three questions. While public health is addressing culture change, guidance is still needed. Additionally, CDC and STLT health departments should use their authority and influence to make the change happen at the state and local system.</li> <li>STLT health departments should continue to think through how they will position themselves to prove value, specifically regarding preparedness.</li> <li>We need to get HHS on board regarding financing.</li> <li>Clarity is needed on the definition of the integration of public health and hospital system and what it will look like.</li> <li>We should continue to be a supporter of shared services and ensure there are no barriers.</li> <li>PHAPs will have important insights and information to share after working in their assignments</li> <li>CDC budget constraints cause great concern. It is important to be kept informed – as STLT Subcommittee thinks about what has been presented today as these constraints will have great impact</li> </ul>
Bruce Dart	<ul style="list-style-type: none"> <li>From a local health department, there is a significant amount of discussion on the public health of the future. Clarity is needed on what this is, what it will look like, and how should it be embraced to assist local health</li> </ul>

Subcommittee Member	Key Takeaways
	<p>departments</p> <ul style="list-style-type: none"> <li>• Clarity is also needed around the integration of public health and clinical care as it is outlined in the ACA. There needs to be support and definition of what this will look like so all health department are on the same page and have an understanding of the future state and related issues.</li> </ul>
Carol Moehrle	<ul style="list-style-type: none"> <li>• There is a high need for clarity of taxonomy used related to core services.</li> <li>• Documentation of success stories related to shared services will be very helpful.</li> <li>• Top priorities for the discussion with AHA should include CHNAs and EHRs. EHRs should be supported at the local level; relationships at that level will be important to this initiative.</li> </ul>
Terry Cline	<ul style="list-style-type: none"> <li>• The principles for implementing CHNAs will also be helpful for application in other areas of public health.</li> <li>• We have this window of opportunity for this massive change, and CDC has incredible leverage in the powers with partners. Input from this Subcommittee and STLT departments will benefit the process in navigating the change and impact.</li> </ul>
James Gillan	<ul style="list-style-type: none"> <li>• It is important to determine the taxonomy in the process of defining core services.</li> <li>• There should be language regarding what public health is capable of and our progress - if progress is tied too much into the accreditation process, there is a possibility we will be set up for failure.</li> <li>• When thinking about the value of shared services, we need to consider that this approach may not be applicable to all STLTs (e.g., Guam). However, shared services are valuable where it is applicable. Documentation of success stories will be beneficial.</li> <li>• There should be a toolkit on ROIs on population health.</li> <li>• CHNAs can bring real change to communities and focus on action; hoping at the end to create community health workers who go into the community and inform health departments about real issues and needs.</li> <li>• More tools are needed for the workforce to enhance their knowledge base and skillset.</li> <li>• Public health needs to determine how to break down the siloes and personal interests to access existing vital surveillance and health data. It is important that we determine the right interfaces to access and share this data, such as open source, as proprietary systems typically have high costs.</li> </ul>
Jewel Mullen	<ul style="list-style-type: none"> <li>• Discussions need to continue on defining the role of public health and health reform and what will be public health's influence on the evolving health system.</li> <li>• The level of influence this Subcommittee can have on the CDC Director to position OSTLTS more firmly across several domains will make a big difference. <ul style="list-style-type: none"> <li>○ Laboratories will be the easiest place to implement shared services, but we need to know what our limits are given the jurisdictions.</li> <li>○ A broader piece of the workforce component is that we really need to know the outputs and outcomes from our relationships with our partners.</li> </ul> </li> <li>• While we continue to focus on the integration between public health and primary health care, we should not forget fundamental public health,</li> </ul>

Subcommittee Member	Key Takeaways
	specifically in such areas that healthcare will not focus on such as climate change.
Dileep Bal	<ul style="list-style-type: none"> <li>• Funding is important when it comes to determining the set of core services.</li> <li>• There needs to be a better linkage to public health systems for EHRs. We need to better market ourselves to the hospitals – proprietary systems currently do have the advantage.</li> <li>• Public health needs to focus on the linkages with financing and determining the return on investments.</li> </ul>
David Fleming (Chair)	<ul style="list-style-type: none"> <li>• The overall message is to seize the day – public health is currently in the right place in time to do the right thing. CDC leadership is positioned to take advantage of the opportunities and work with STLT health agencies to enhance public health.</li> <li>• When defining core services, we need to be mindful of what is the role of public health in this health reform era.</li> <li>• The STLT Subcommittee should rethink the recommendation related to financing as the landscape is changing. CDC has already begun to expand this recommendation, and this Subcommittee can be engaged in finalizing the recommendation and support the relevant ongoing work.</li> </ul>

**XIII. Public Comment**

Dr. Fleming asked if there were any public comments on the phone or in the meeting room. No comments were offered.

**XIV. Closing (OSTLTS Updates)**

Dr. Monroe provided an overview of the post-organizational review that was conducted for OSTLTS. Four main recommendations were provided in the review.

- Recommendation #1: Refine the strategic plan by reviewing the initial core mission and functions of the Office.
- Recommendation #2: Establish a portfolio management process
- Recommendation #3: Create a plan for organizational sustainability and implement an OSTLTS onboarding process
- Recommendation #4: Enhance CDC’s internal collaboration and communications

The mission of OSTLTS has been a “living document” as the priorities and landscape of the health system continues to evolve. The overall work and role of OSTLTS is not expected to drastically change as a result of the recommendation from this review, but focused support can shift as priorities emerge. The State Innovation Model (SIM) Initiative, CMMI, and the growth of NPHII have had high impact on the support provided to STLT health departments. Overall, integration of public health and health care has emerged as a top priority, and OSTLTS will continue to work cross-agency and with STLT health departments to support efforts within the transforming health system. Other programs (described at the beginning) will also continue.

**Conclusion**

The next Advisory Committee to the Director will take place on October 25, 2013 when Dr. Fleming will provide an update on this Subcommittee’s activities. The next meeting of the STLT Subcommittee will be scheduled in November or December. As there was no further business, Dr. Fleming thanked the Subcommittee members and CDC staff and called the meeting adjourned.