

Meeting Summary

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

Friday, October 10, 2014
8:30 am– 4:00 pm (EDT)
CDC, Atlanta, GA

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

Chairperson: David Fleming, MD

Designated Federal Official: Judith A. Monroe, MD

STLT Subcommittee Members Present: David Fleming (Chairperson), Terry Allan, Bechara Choucair, Terry Cline, Mary Currier, Georgia Heise, Carol Moehrle, Jose Montero, Mary Selecky

CDC Presenters: Judy Monroe, Denise Koo, Liza Corso, Craig Thomas, John Auerbach, Chesley Richards, Laura Seeff

Others present (and announced): Judy Lipshutz, Debra Bara, Perry Smith, Lauren Boyle-Estheimer, Roberta Erlwein, Vickie Boothe, Kristin Brusuelas, Stuart Berman, Andrea Young, Delight Satter, Amy Loy MacKenzie, Kate Agin, Brian Lee, Harald Pietz, Sylvia Brown, Michael Iademarco, Leandris Liburd, Craig Wilkins, Georgia Moore, Shauna Mettee, Paula Staley, Sam Taveras, Jessica Fisher, Mark Jorritsma

Notes: Erin Malone, Sara Shier (CDC Contractors)

Meeting Summary

I. Welcome/Call to Order

Dr. David Fleming welcomed the STLT Subcommittee members and reviewed the Federal Advisory Committee (FACA) regulations. As a FACA, meetings are 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. All acknowledged the fact that health departments receive CDC funding. There was no other conflict of interest declared.

III. Meeting Goals

The objectives for this meeting were as follows:

- Receive updates from CDC on key agency issues
- Review work of the STLT Subcommittee Think Tanks and finalize recommendations that will be presented at the director meeting
- Review progress of previous work done by the Subcommittee and CDC

IV. CDC Updates

Dr. Judy Monroe welcomed the new and returning members and provided a quick update on Agency priorities and updates for CDC's Office for State, Tribal, Local, and Territorial Support (OSTLTS).

CDC Priorities

Dr. Monroe provided an overview on CDC activities and the three priority strategic goals 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

CDC Challenges

The Ebola epidemic and Enterovirus D68 are high profile challenges for the Agency right now. As of October 8, 2014 the World Health Organization (WHO) reported over 8,000 identified cases of Ebola and over 3,800 deaths from the disease. The primary objective is to interrupt transmission of Ebola in West Africa. Public health does well in case identification and isolation, contact identification, and monitoring. The Ebola response is the largest global response in CDC's history and includes a number of task forces: medical care task force, global migration task force, and state coordination task force. In addition, CDC is reaching out to partners and experts in public health, including members of the STLT Subcommittee. Another CDC challenge right now is Enterovirus D68, which is garnering a lot of CDC attention with the nationwide outbreak. There have been 678 confirmed cases in the U.S.,

Meeting Summary

and five deaths. Almost all confirmed cases have been children.

CDC Leadership Changes

John Auerbach has joined CDC with the Office of the Associate Director for Policy (OADP), and Debra Houry is the new Director of the National Center for Injury Prevention and Control (NCIPC).

OSTLTS Updates

- OSTLTS is the three-time winner of CDC's healthiest CIO contest.
- The Public Health Associate Program (PHAP) continues to grow. A new class of associates started on October 1st with the new fiscal year. This class will be positioned in 39 states, D.C. Puerto Rico, and three tribes.
- There has been major growth and development with national partners. OSTLTS is managing approximately 25 national partners on behalf of CDC.
- The Division of Public Health Performance Improvement is finishing up the 4-year National Public Health Improvement Initiative (NPHII). DPHPI is also responsible for the Prevention Status Report (PSR), which is available online and has had 70,000+ page views and 30,000+ downloads. In addition, the Public Health and Health Services block grant has transitioned to OSTLTS from the Chronic Disease Center (NCCDPHP), which managed this effort for 25 years.
- There has been significant progress on public health accreditation with 54 public health departments receiving accreditation as of mid-September.
- Public Health Law Program has completed over 25 publications this year and trained 2,800 people in health law issues.
- The Tribal Support Unit has fully populated the membership on the tribal advisory committee (TAC).
- The Field Services Office has been renamed the Stakeholder Outreach and Engagement Unit (SOEU) and will continue to support STLTS, especially in health system transformation. Harald Pietz has been named acting director for this unit.

Areas for Input

Dr. Monroe has been asked to be the point of contact for rural health and OSTLTS will serve as the lead on rural health for CDC. Her experience in rural health will be a strong asset in this work. HRSA has asked her to speak at an upcoming national rural health meeting which can contribute to launching CDC's work in this area. Input from the STLTS Subcommittee on how OSTLTS can effectively approach this new assignment would be welcome.

Questions / Comments

Dr. Fleming opened the floor for any questions or comments for Dr. Monroe on CDC's priorities or challenges.

- *Accreditation:* The committee recognized the growing number of accredited health departments and those in the pipeline for accreditation.
- *Ebola:* The disease is a high priority issue and it is distressing to see the failed state of healthcare in West Africa. As the epidemic becomes global and comes to the U.S., it will highlight potential local vulnerabilities in this country. Resources available at the state

Meeting Summary

and local level have been declining since 9/11 and anthrax. The question was posed to STLT Subcommittee members about whether they are hearing concerns and questions through STLT networks about how to prepare domestically. Responses:

- Public health workforce—The regular turnover and constant need for trainings in preparedness raise concerns. In addition, the public health workforce has lost personnel due to economic downturn and reductions in preparedness funding.
- Sustained capacity-- Public health does a good job at responding immediately to crises, but sustained response taxes the system. How long can we maintain this level? Being successful at responding to and containing these incidents also leads to the cloak of invisibility. How do we maintain heightened awareness and vigilance and continue to highlight the importance of preparedness?
- Opportunity of the crisis --There an opportunity for CDC and others to highlight the systems in place and successful efforts (e.g. contact tracing) with other diseases like meningitis or TB. This may be a moment to educate the public.
- Committee members recognized and thanked Dr. Monroe and CDC for reaching out to local and State health departments and building invaluable partnerships.
- *Rural Health:* Appreciation was expressed for the new focus on rural health because of such issues as access to care and public health capacity. A focus on rural health from CDC is needed to create a conceptual approach to public health in rural areas.
 - CDC might explore new language in grants and cooperative agreements, translating social determinants of health for the local level, and measuring and providing data that is relevant for those groups.
 - The standards for public health services in rural areas, such as EMS response time, should also be examined. It would be useful to think through a realistic urban / rural lens when advocating for increased public health resources. What is an acceptable “standard” for public health services?
 - Another issue for rural health is data and lack of technology infrastructure. Developing medical access through telehealth is a big push, but technology is a limiting factor. This might come forward as a critical issue for rural health.
 - Additionally, CDC should consider the innovation in shared services and clinical care; collecting and sharing these innovations would be useful.
- *Climate Change:* Many health departments are trying to learn where they fit in the climate change conversations.

V. Progress Report Highlights: 2012 Recommendations

Dr. Monroe provided background on the 2012 recommendations for new committee members. The CDC Advisory Committee to the Director (ACD) adopted 12 recommendations in October 2012 put forth by the STLT Workgroup (now Subcommittee) intended to support health departments as they faced a changing economic and policy climate including implementation of the Patient Protection and Affordable Care Act (ACA). Recommendations were intended to help STLT health departments respond to growing demands, decreasing resources, and evolving system changes that call for planning greater efficiencies as well as new approaches to protecting the health of the public. Recommendations fell into four categories:

1. Clinical care and public health linkage options

Meeting Summary

2. Core services in public health
3. Shared services-regionalization options
4. Workforce development needs for public health

Summary of Progress

The table below provides a high level summary of progress made against the 2012 recommendations. Additional information was provided in the handout titled, “Progress Report: Health Department of the Future.”

RECOMMENDATIONS	PROGRESS*
1. Clinical Healthcare and Public Health	
Public Health role in non-profit hospital requirements for community health needs assessment/strategies	Progressing well
Exchange of EHRs across Clinical Care and Public Health Systems	Initiated
Financing for Population Health	Complete but ongoing
2. Core Services in Public Health	
Current Practice and Thinking regarding Core Public Health Services	Complete but ongoing
Stakeholder Process for Guidance on Core Public Health Services	Progressing well
3. Shared Services/Regionalization	
Shared Services Clearinghouse	Complete but ongoing
Encourage/Incentivize Use of Shared Program Services	Complete but ongoing
Support and Add Value to Existing Shared Services Initiatives	Progressing well
4. Workforce Development	
Vital Public Health Workforce Gaps	Complete but ongoing
Core Competencies in CDC Training Programs	Partially complete but still in progress
Public Health Workforce in Partnership with Healthcare System	Complete but ongoing
Realignment of Public Health School Curricula	Complete but ongoing

*Progress Scale				
Initiated	Progressing Well	Partially complete but still in progress	Complete	Complete but ongoing

UPDATE: Community Health Needs Assessment (CHNA)

Dr. Denise Koo reported on progress made towards the 2012 recommendation: public health role in non-profit hospital requirements for community health needs assessment/strategies.

- This recommendation is progressing well, and highlights include:
 - CDC is working to identify effective partners and not duplicate existing efforts.
 - CDC is developing a technical package targeting not-for-profit hospitals which includes an infographic, links to tools, and a queriable data base with upstream and downstream interventions.
 - CDC is also exploring potential partnerships to further support these efforts with Robert Wood Johnson Foundation, American Hospital Association, and others.

Meeting Summary

Discussion: Community Health Needs Assessment (CHNA)

- CDC has been collaborating with other HHS partners around rural health on CHNA and will continue to engage these stakeholders to determine what their needs are and how to publicize resources they can use to address this unique population.
- Terminology is also an important consideration for engaging with different stakeholders. As hospital and healthcare systems focus more on population and community health, they need to consider how they are communicating this message (e.g. changing language from health to wellbeing as health is often construed narrowly just as healthcare).
- Questions were raised about whether CHNAs are being used by hospitals and if benefits are being seen in the community. Concerns are that some hospitals are just “checking the box” re: community benefits. Nonetheless, there is increased recognition of value-based care so benefits to the community might help.
- There are also questions about overlapping service areas and competition for who gets credit for community benefit. It is important to consider aligning with and building upon existing work.
- There should be continued encouragement for state and local health departments and hospitals to work together and CDC will continue to provide leadership and what is asked for. CDC needs to get the word out about what is available and has actively started to develop a communications strategy.

UPDATE: Core and Shared Services

Liza Corso provided information on the progress made towards the 2012 recommendations related to core and shared services.

- Highlights of activities responding to the Core Services recommendations:
 - State enabling authorities assessment for fundamental activities
 - CDC participation in RWJF-funded activities related to Foundational Public Health Services (FPHS)
 - Assistance with dissemination and vetting of Version 1 draft of FPHS
 - Next Steps:
 - Upcoming RESOLVE workgroup meetings
 - Considerations for how to use FPHS in relationship to financing issues
 - Further elaboration on relationship between accreditation and FPHS
- Highlights of activities responding to Shared Services recommendations:
 - Conducted CDC-wide data call for programs and activities that support, foster, or allow for shared services across jurisdictions
 - Development of CDC website focused on Cross-Jurisdictional Sharing (CJS)
 - Fostering shared services through CDC initiatives
 - Ongoing CDC involvement in Center for Sharing Public Health Services

Discussion: Core/Shared Services

- Great appreciation was expressed on behalf of STLTs for leadership in moving forward on defining foundational capabilities for public health. This work is critical. It is important to make sure the work through the Public Health Accreditation Board, the foundational capabilities work and the work on shared services is connected to achieve synergies where possible. Sustaining foundational capabilities is a critical focus area that the next version of this work needs to address.

Meeting Summary

- When talking about “shared services” it is important to expand the sharing concept to include “across programs and/or grants” not just jurisdictions.
- Use of the term “core services” may lead to the question about what else is needed after core services are provided. This can be problematic.
Response: The term “foundational service” was chosen instead of core services, minimum package or other terms to imply they should be built upon rather than limited to specified services. Also note that foundational capabilities and accreditation are not the same. Public health accreditation represents standards that need to be met year after year.
- It is important to emphasize that defining foundational capabilities does not mean “we’re taking something away” but rather that we are defining what is foundational, what is necessary to sustain other services/activities. This is an important communication issues that must be carefully addressed.
- There is often conflict about funding flexibility or sharing funding between programs. This especially rings true in preparedness and crisis management. Often, when additional help is needed, it is hard to mobilize use of personnel or resources between funding streams. The Office of the Inspector General conducting audits needs to be brought into the funding flexibility/sharing discussions.
- It is important to build strong relationships between jurisdictions and across State lines where appropriate to ease the ability to share services when needed.

UPDATE: Financing Models / Relationship with CMMI

- Dr. Monroe highlighted progress on recommendations related to financing:
 - CDC has a robust relationship with CMS Innovation Center on development of population health delivery and payment models (e.g., category 4 of Health Care Innovations Awards Round 2, State Innovations Models Awards Round 2).
 - CDC and HRSA have continued to work together to operationalize the recommendations of the 2012 IOM report.
 - CDC has developed an informational primer which identifies challenges and important opportunities to establish effective, more sustainable community-focused delivery and payment models to improve population health.
 - CDC is developing recommendations for how to increase its support to health departments in building and sustaining their capacity to bill for public health services.

Discussion: Financing Models / Relationship with CMMI Updates

- In regards to financing, public health needs to consider where the money should flow. There should be no expectation for a national formula for changing payment systems since different models are needed in different states. Public health should be exploring what works to support its services and where money should optimally be spent.
- From a public health perspective, the key to the transformation is changing the financing systems to drive toward improving population health. Public health needs to have a seat at the table and provide expertise in addressing upstream interventions. Public health can play a role of communicating with partners to ensure the healthcare systems does not duplicate work that is already being done.

Meeting Summary

VI. Public Health Finance Think Tank Report

Terry Cline, chair of the finance think tank, and Craig Thomas (SME from OSTLTS/CDC) provided an update on the progress of the public health finance think tank. The charge is: *To identify opportunities and propose recommendations to strengthen the financing for public health services in light of funding shifts in federal and STLT budgets.* The think tank convened monthly beginning in May 2014 with an initial focus on improving the accountability and transparency of the Preventive Health and Health Services (PHHS) Block Grant.

Progress to Date

- Created and distributed Block Grant program guidance to promote grantee investments towards a balanced portfolio that includes urgent and emerging health issues, achievement of national public health standards and accreditation readiness activities, and support for the foundational capabilities. (Guidance document was distributed to meeting attendees).
- Drafted recommendations for improving the accountability and transparency of the PHHS Block Grant for consideration by the STLT Subcommittee.

Recommendation #1

- Recommendation #1 – Strengthen CDC business practices and administration of PHHS Block Grant
 - Within the next 12 months, CDC should review its internal processes regarding awarding Block Grant funds to grantees and supporting completion of its responsibilities under the Block Grant in a timely manner.
 - Unless prohibited by appropriations language, we recommend that CDC review, identify, and implement strategies and internal business practices that allow the timely disbursement of Block Grant funds scheduled during a given fiscal year (FY).

Discussion: Recommendation #1

- The think tank should draw on institutional memory, while also using present opportunities. It will be important to maintain the flexibility inherent in the block grant while increasing transparency and creating program guidance designed to improve internal controls and consistency. .
- ASTHO has collected stories about Block Grants that can contribute to an “evidence base” for how these funds are used.
- Beyond OSTLTS, other CDC stakeholders that should be engaged in the implementation of this recommendation include cross agency connection points such as, PGO, OD, and OCFO.
- Communicating the need for and value of strengthening business practices to those without a public health background will need to be a consideration. It will be important that these improved practices are seen as enhancements rather than directive changes in program direction or intent.
- Challenges with block grant management should be addressed. For example, sequencing problems produce delays in federal appropriations that make CDC unable to put out a first quarter funds and limits grantees ability to receive and spend funds. If CDC can put

Meeting Summary

money out earlier, it would help grantees. Another sequencing challenge is at the back-end of the support channel. Sequencing the fall out money could be improved if it was before July 1 rather than after, as it currently operates. CDC should explore ways to make this less burdensome and less redundant so money gets where it needs to go faster.

- The committee decided that recommendation #1 will incorporate the above ideas so that readers are aware of the issues.

Recommendation #2

- Recommendation #2 – Develop a plan for measuring the impact of the PHHS Block Grant
 - Over the next 16 months, CDC should engage grantees and other stakeholders in the development of a plan for improving the programmatic focus, measurement, and fiscal reporting of PHHS Block Grant services, projects, and activities to better demonstrate individual and collective impact.

Discussion: Recommendation #2

- Language will be key to stakeholder interpretation and acceptance of the recommendation. Keeping the traditional flexibility of the block grant is critical, but that very flexibility makes the work completed under the grant difficult to measure/evaluate. Finding a balance between maintaining flexibility and creating measures is the central challenge. Language in the recommendation should be changed so that it is clear the list is not inclusive.
- The timeframe of 16 months was chosen as think tank members believe it will provide enough time to address the recommendation.
- The think tank should consider the relationship between recommendations #2 and #3 and how to gauge effectiveness through stories verse measurement and assessment. A combination of the two will be the most robust when demonstrating impact. Numbers as well as the strength of anecdotal information. The stories may have a shorter timeline and therefore a greater initial impact compared to traditional measurement, which requires a longer timeline. There is a potential to divide data into buckets that can then be used to guide recommendation #3. The committee may need to consider reordering the recommendations to reflect the timelines and impact.

Recommendation #3

- Recommendation #3 – Communicate current PHHS Block Grant achievements
 - Over the next 12 months, CDC should work collaboratively with the field to develop and implement an initial communications plan that includes strategies for generating individual and program wide success stories and standardized reports to stakeholders.

Discussion: Recommendation #3

- The block grant affects multiple audiences so communications and stories should be tailored to reflect the varied needs, interests, and priorities. In implementing this recommendation CDC will need to remember not only the strengths but also the limitation of stories.

Meeting Summary

Recommendation #4

- Recommendation #4 – Identify new and existing potential opportunities to finance foundational capabilities
 - In the next 12 months, CDC should conduct an assessment of the factors and strategies that support the financing of the foundational capabilities.

Discussion: Recommendation #4

- The recommendation originally called for initiation (rather than completion) of the work within 12 months because work on the foundational capabilities continues to evolve. Ultimately the recommendation was revised to call for more concrete endpoint of 12 months, using whatever information is available within a year but recognizing that the results may not be conclusive.

Identified Challenges and Opportunities

- The think tank requires additional preparation to address other financing opportunities (e.g., innovative funding, social impact bonds) and will share input at a later date.
- The think tank also recognizes that many other CDC initiatives address innovative financing, so scope of the work will need to be more clearly defined.

ACTION: The STLT Subcommittee unanimously approved the 4 Public Health Finance Think Tank recommendations for proposal to the Advisory Committee to the Director at their fall meeting.

VII. Social Determinants of Health Think Tank Report

An update on the progress on the social determinants of health (SDOH) recommendations was co-presented by Dr. Jose Montero, chair of the SDOH Think Tank, and former chair, John Auerbach (chaired through 9/30/14). The think tank was initiated in February 2014, and had two recommendations adopted by the ACD in April 2014. A CDC cross-CIO workgroup was formed to address the adopted recommendation related to non-health data sources:

- CDC should explore the available non-health data sources from other domains (e.g., housing, human services, education, transportation, public safety, income) that are readily available and that offer insights into the impact of the social determinants of health. CDC should also explore ways STLT health agencies can collect and incorporate such data in their planning.

Progress /Update

- The internal CDC workgroup has completed an initial assessment of non-health data sources.
- Multiple sources exist but are not necessarily known about/used by health departments, not easily accessible, or not coordinated in one place.
- The think tank recommends promoting use of the updated Community Health Status Indicators (CHSI) tool to address the challenges outlined above. The CHSI tool includes multiple SDOH datasets and links to indicator measures. CHSI is expected to be cleared within CDC within the next couple of months. The proposed recommendation language

Meeting Summary

and feedback are included below.

Community Health Status Indicator (CHSI)

- Vicki Boothe, the project lead for CHSI, provided an overview of the CHSI updates and a demonstration of the tool. CHSI is designed to improve the ability of government agencies, healthcare providers, community organizations, business leaders, policymakers, and members of the public to
 - comprehensively assess health status and needs;
 - develop a shared understanding of the factors that drive health (i.e., social determinants);
 - prioritize focus areas and work collaboratively toward improvement; and
 - measure progress over time.
- CHSI focuses on overall population health and includes more than 200 indicators, including measures for all categories of health determinants (health care, behaviors, social factors, and the physical environment). It has the ability to compare indicators among peer counties across states and includes census tract maps to identify concentrated areas (hot spots) of social and environmental risk factors.
- CHSI provides links to data within the tool and utilizes the data to paint a picture of a designated geographic area; CHSI does not maintain the data sources.

Interventions addressing SDOH

- There are several intervention databases available or soon to be available, including: the Community Guide, Community Health Improvement Technical Packet (12/2014) and Healthy People 2020 SDOH Interventions (Fall 2014). Further exploration of how to help STLT health agencies access these databases and other interventions is still under way.

Connecting data to action

- The SDOH think tank has begun to explore a CDC-conceptualized decision-tree tool aimed at helping public health agencies figure out how to approach SDOH in their communities. The tool would follow a logic that identifies
 1. a social determinant in a community that is associated with morbidity/mortality (in CHSI tool)
 2. how that determinant can be measured (in CHSI tool)
 3. what evidence-based strategies might improve that measure
 4. who should be partnered with to address it
 5. some good examples of interventions that have worked in other areas

Proposed Recommendation:

- To address the non-health data sources recommendation, the following more specific Recommendation (V1) was proposed:
 - *CDC should endorse and support expansion of the Community Health Status Indicators tool (CHSI) to incorporate additional SDOH.*
 - *CHSI should be promoted in the context of a larger CDC framework on how Public Health can collaborate with traditional and non-traditional partners to*

Meeting Summary

improve population health through addressing key SDOHs.

- The Subcommittee suggested slightly revised wording for the recommendation (V2):
 - *CDC should support expansion of approaches like the Community Health Status Indicators tool (CHSI) to assist health departments to better understand and modify SDOH in their jurisdictions.*
 - *Special attention should be paid to the timeliness of data and to their direct application to actions that improve the health of the population.*

ACTION: The STLT Subcommittee unanimously approved the recommendation (V2) as revised for proposal to the Advisory Committee to the Director at their fall meeting.

Discussion

- Question was asked if other determinates should be incorporated into the CHSI tool and if certain determinants might be considered which only apply in some areas (e.g., urban versus rural needs.)
 - Current criteria indicate measures for determinants must be available/relevant to any geographic area. The tool can be expanded to more narrowly define criteria for particular situations.
- A major challenge identified by the SDOH think tank is how to use the data identified and connect determinants to action.
- CDC will need to ensure the tool reflects the most current available data.
- The following are questions to consider in moving from SDOH data to action. Once a jurisdiction defines, measures, and analyzes underlying SDOHs:
 - What is the role of the health department (HD)?
 - What is practical for a HD to take on?
 - What are the barriers to addressing SDOH and how can they be overcome?
 - Can HDs help “shine a light” on existing efforts to address SDOH?
 - How can CDC help?

Next Steps

- CDC will consider where SDOH are already being addressed and identify areas where public health can carve out or strengthen its role. Examples include:
 - Community benefit efforts (not-for-profit hospitals)
 - Built communities, partnerships with other agencies/organizations, etc. currently NOT being evaluated for health impact
 - New healthcare funding models (e.g., ACOs, ACHs, SIM)
 - Disease-specific programs
- In addition the SDOH think tank and CDC will consider the following to support a broader reach in the use of SDOH:
 - Breaking down barriers to HD engagement (e.g., legal, political, non-traditional partnerships, redefining traditional role of PH, resources):
 - Identifying CDC mechanisms that might routinely incorporate SDOH (e.g., FOAs, inclusion in guidance)

Meeting Summary

- Expanding partnerships with non-health agencies at federal level
- Expanding partnership with non-health NGOs

VIII. Public Health Surveillance Think Tank Report

Dr. Bechara Choucair, Chair of Public Health Surveillance Think Tank, and Dr. Chesley Richards (SME, OPHSS/CDC) provided an update on the progress of the public health surveillance think tank. The think tank met briefly in August and more extensively on October 9, 2014. The objectives are two-fold:

1. In support of the CDC Surveillance Strategy, help CDC better conduct its work in informatics and surveillance through the lens of local/state health agencies facing the need for systems that produce information across diseases and conditions at the state/community level.
2. To provide guidance to CDC in how to best help public health agencies more effectively engage in the evolving health system through their information sharing activities.

The following questions are guiding the current work of this group:

- With a long term vision for surveillance system, what would resonate with and be helpful to STLT agencies?
- What can CDC do in informatics and surveillance to better support or produce action at the state/community level?
- What can CDC do to assist public health agencies to effectively engage health system data and information?
- How should the work be prioritized moving forward?

To initiate this work, the think tank proposed several recommendations to propose to the Advisory Committee to the Director:

Recommendation #1

- Recommendation #1 – Formally Endorse CDC Surveillance Strategy
 - Do not significantly modify or change plan for 2 years.
 - Stay the course—chart the course—celebrate successes of surveillance.
 - Connect to the Health Department of the Future, as well as CDC of the Future.
 - Surveillance should focus on what we need to improve or protect health
 - Parsimony, particularly around requirements, data standards, and funding

Discussion: Recommendation #1

- The think tank should consider changing the language to reflect a recommendation rather than an endorsement.

Recommendation #2

- Recommendation #2 – Formalize a Roadmap Process for Adoption and Implementation of Harmonized Data Standards for CDC surveillance systems
 - Balance flexibility and prescriptiveness in harmonizing standards

Meeting Summary

- Consider role of funding in supporting use of harmonized standards

Discussion: Recommendation #2

- The think tank should consider adding a realistic timeline to the recommendation (e.g., 16 months).
- The roadmap will aim to assist the transition to electronic notifiable disease reporting. Everyone is sensitive to limited health department resources and ramifications at the state and local level.
- Changing the coding will also affect hospitals, providers, etc. Any recommendation should consider the impact of potential resistance and growing pains during the coding transition.

Recommendation #3

- Recommendation #3 – Endorse development of an informatics/surveillance workforce plan. The plan should consider:
 - Training for existing workforce or training in place (first priority)
 - Resources would need to support such training
 - Inclusion of language in CDC FOAs to encourage funding for training
 - Expansion of training for workforce for skillsets that don't typically exist in public health (i.e., modelers, engineers, data scientists) (second priority)
 - Need to define use cases for where and when such skills would be helpful
 - Consider National Health Service Corps approach—payback commitments

Discussion: Recommendation #3

- Consider training the people who have a strong interest and have vocalized desire to be, and stay, in public health rather than devoting excess funds to internships, fellowships, etc. for people who may not stay within the public health field.
- The recommendation language should be adjusted to specify that the recommendation is public health specific and will not apply to the entire healthcare workforce.

ACTION: The STLT Subcommittee unanimously approved the recommendations from the Public Health Surveillance Think Tank with suggested revisions/edits, including language that reflects recommendations (vs. endorsements). Recommendations will be proposed at to the Advisory Committee to the Director at their fall meeting.

Future Surveillance Think Tank Discussion Items

- Leverage successes that are funded with foundation or private sector/nonprofit investments for longer term investments of federal and other public funds.
- CDC should foster integration of innovations in a sound, evidence-based way (e.g., community guide like approach)
 - Explore the role of EHR, and other non-health data sources in use for public health action
- Framework of systems for research vs. surveillance vs. core surveillance
- Explore/address tensions between data needs at the local and state level vs. federal level for public health action.

Meeting Summary

- CDC's role in:
 - Assembling national data systems for local use
 - Promoting data tools to simplify data analysis and visualization solutions
 - Promoting utilizing data scientists in other industries without moving into public health jobs
 - Promoting peer to peer assistance
- Rural vs. urban needs: workforce, data, and tools

Challenges and Opportunities

- *How to communicate the need for informatics* to the next generation of public health professionals, beyond just schools of public health.
- *Increasing need for cross-system data to inform health status.* The concept will need advance planning, but a defined information system of the future should have local perspective and CDC/population health perspective. Recommendation #1 may incorporate some of these principles.
- *Need for explicit actions related to Interoperability as part of the surveillance strategy.* This will be crucial to ongoing success and usefulness to providers, hospitals, public health, etc.
- *Consideration of innovative approaches* (e.g., social media) that could be used in local and state health departments.
- *Explicit use of predicative analytics and modeling* which should not be left as an assumption. Current partnerships are with the private sector, but should eventually transition modeling as an internal PH capacity. Examples of predictive analytics in use:
 - Harvard Business Review – partnership with private sector to model which restaurants are most likely to have healthy food items
 - University of Chicago – big datasets used to predict which kids will develop lead toxicity in the next year

IX. Public Health – Healthcare Collaboration Workgroup Report

Dr. Laura Seeff provided an update on the public health – health care collaboration workgroup progress. The workgroup has proposed four recommendations for CDC to consider. These recommendations will be presented to the Advisory Committee to the Director at their fall meeting and will be available broadly once approved. The intended outcome or charge of the workgroup is: promote health system that delivers health and non-health services and increases clinical and community prevention to improve population health and cost outcomes. Initial conditions and risk factors include: hypertension, tobacco, healthcare-associated infections, teen pregnancy, asthma, and diabetes /pre-diabetes.

Proposed Recommendations

- Proposed recommendation #1 – Support a more coordinated health system that links clinical care, social and behavioral health services, and public health to achieve greater impact.
- Proposed recommendation #2 – Fully leverage ACA requirements that not-for-profit hospitals conduct community health needs assessments (CHNA) and community health improvement planning (CHIP) to improve community health.
- Proposed recommendation #3 -- Align performance measurement and improved public

Meeting Summary

health and clinical data system interoperability with federal and non-federal, national and state stakeholders to increase health system accountability.

- Proposed recommendation #4 -- Develop guiding principles to support active engagement between state and local public health, the health care system, and other community stakeholders.

Discussion: Proposed Recommendations

- CDC should consider integrating recommendations with cross-cutting / overarching themes.
- The workgroup will discuss adding timelines (e.g., 16 months) to some recommendations during the next meeting on October 23rd, and will continue to roll out action items under recommendation #2.
- Recommendation #1 is the biggest lift and will need to maintain endurance to make sure it comes to fruition and includes operationalizing steps.
- CDC and local /state health departments should avoid duplicating efforts around CHNA and healthcare reform workgroups.
- In regards to recommendation #2, 'corporate' is currently leading the charge, but public health needs to take ownership.
- CDC should explore community preventative services beyond the traditional public health definition, including: housing services, employment, and other human services. CDC needs to explore how they can assist, what is needed, and how to communicate with other stakeholders.
- Proposed recommendation #4 should make SDOH more explicit and talk about social investment to improve health outcomes.

X. Emerging Issues / Agenda for Upcoming Year

Dr. Fleming wrapped up the formal agenda of the STLT Subcommittee by sharing that all recommendations discussed have been approved (with some amendments/edits) and will be shared during the upcoming Advisory Committee to the Director meeting on October 23rd. The subcommittee members were asked to share their reflections of the day, focusing on two items: 1) key takeaways from current issues and recommendations, and 2) thoughts on future and emerging issues in public health.

Key Takeaways

- There are many opportunities for increasing collaboration and integration of public health and healthcare, and the focus should continue to be on community benefits.
- The recommendations and work of the committee tie directly to the transformation taking place in healthcare across the U.S. It will be important for CDC and the committee to socialize these recommendations and continue to vocalize these issues to the Director.
- There should be a continued focus on establishing a common language and moving away from talking about healthcare to talking about population health and well-being, and to stay away from using too many acronyms when dealing with systems collaboration.
- CDC and the committee should continue sharing success stories to build momentum for public health. Dr. Monroe asked the Subcommittee members if it would be helpful for OSTLTS to house a bank of success stories and topics online. All agreed that it would be a helpful resource for local and state health departments.

Meeting Summary

- There should be continued focus on public health infrastructure and foundational capabilities, including linking accreditation and financing. The committee should continue to explore strategies that make the public and policy makers aware of the importance of those foundational capabilities/services.

Emerging Issues / Ideas

- Payment reform and realigning incentives is a major issue for public health. Figuring out how to leverage other parts of the health care system (e.g. hospitals, CMS) to provide continued funding and support to public health work is crucial.
- OSTLTS should serve as a model for other federal agencies to interact and communicate with STLTS. For example, a recent poll of states about preparedness to accept potential Ebola patients caused confusion among stakeholders.
- An additional issue for the Subcommittee to consider is the role of disruptive innovation in public health. One example is partnering with the private sector to create an algorithm to predict failure of restaurants in health inspections. This type of innovation can elevate the profile of public health and the role of government. The Subcommittee should consider how the CDC could support innovative concepts in local and state government and vice versa. CMMI is a good example of federal innovation and CDC should continue to partner and collaborate with them. The second round of SIM funding and the population health plan is an example of where CDC has been involved in innovation.
- Cross-sector investment is an emerging issue for public health. Using a place-based approach to improving public health will require collaboration with not only healthcare, but also with other non-health sectors (e.g. education, private, community development). The Subcommittee should consider how public health can effectively coordinate and enable local place-based, cross-sector investment and ensure metrics and measurement are put in place early.

XI. Public Comment

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

XII. Conclusion

The next Advisory Committee to the Director is scheduled for October 23, 2014* where Dr. Fleming will provide an update on this Subcommittee's activities and ask for approval of the new recommendations. More information is forthcoming about the next STLTS Subcommittee meetings. As there was no further business, Dr. Fleming thanked the Subcommittee members and CDC staff and asked that the think tank chairs take responsibility for moving the work forward. Dr. Fleming called the meeting adjourned.

*ACD meeting was postponed with new date TBD