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Meeting Notes
State, Tribal, Local and Territorial (STLT) Subcommittee

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October 21, 2015	8:30 am – 3:30 pm EDT
CDC, Roybal Campus	Building 19, Room 254-255

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STLT Subcommittee Attendees: Jewel Mullen (Chairperson), Terry Allan, Mary Currier, David Fleming, James Gillan, Georgia Heise, Jose Montero, Julie Morita, Umair Shah, John Weisman, Ed Ehlinger (on phone)

Other Announced and Present Attendees: Judith Monroe (Designated Federal Official), John Auerbach, Judy Lipshutz, Mary Hall, Ed Baker Roberta Erlwein, Matthew Olivares, Kenneth Robinson, Chesley Richards, Delight Satter, Elizabeth Skillen, Sonia Tetlow, Preetha Swamy, Andrea Young, Heather Duncan, Liza Corso, Craig Thomas

Notes: Coretta Monroe (CDC Contractor), Aliyah Ali (Associate Services Fellow)
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Welcome/Call to Order
- Dr. Jewel Mullen welcomed the STLT Subcommittee members
- All members introduced themselves and disclosed any conflicts of interest. None were declared beyond existing CDC support for Health Departments.
- Dr. Mullen paid a special welcome to new STLT Subcommittee members: Ed Ehlinger, Julie Morita, Umair Shah, and John Weisman. She also acknowledged the resignation of one STLT Subcommittee member, Dr. Terry Cline, due to increased professional role demands. Dr. Cline sent his regards and indicated how much he appreciated the great opportunity of working with the STLT Subcommittee.

Meeting Goals
- Receive updates from CDC on key agency issues
- Review work of the STLT Subcommittee Think Tanks and progress on previous recommendations adopted by the Advisory Committee to the Director (ACD)
- Finalize recommendations that will be presented to the ACD at their October meeting

CDC Update
Dr. Judy Monroe provided a an update on CDC and OSTLTS priorities

CDC
Dr. Monroe set context of her update with 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 the collaboration between public health and healthcare

Dr. Monroe encouraged the committee members to visit the Ebola photo exhibit in the lobby and stated that it demonstrates some of the ongoing work accomplished including almost 3,000 Ebola deployments to date, with over 3,500 CDC staff involved in Ebola response in some way.

OSTLTS Update
- The CDC funding tool has been updated and is now available online
- Communication
    - "Did You Know?" Newsletter with over 31,000 subscribers, and with partner syndication, the number of subscribers swells to over one million.
    - Continue to participate in hospital network calls
    - Feedback from Health Officers has led to improved Health Officer Orientation training

- Despite the closeout of the National Public Health Improvement Initiative (NPHII) in September 2015, Craig Thomas (Director, Division of Public Health Performance Improvement/OSTLTS) has developed a robust evaluations team, who won the 2015 CDC Outstanding Work award.
- Under the leadership of Sam Tavares' leadership, we now manage 25 national grantees in Partnership Support, which facilitates over $100 million dollars in funding across the Centers, Institutes, and Offices (CIOs) at CDC.
- The Department of Homeland Security now uses the OSTLTS guidance to develop funding mechanisms.
- The OSTLTS 2015 Prevention Status Report (PSA) will be released shortly.
- The PHHS Block Grant, which was transferred to OSTLTS from Chronic Diseases in 2014, is flourishing and compliance visits are scheduled for the next three months.
- The number of accredited Health Departments continues to rise and 38 departments are currently in the queue for review.
- The Public Health Associate Program (PHAP) exceeded their goal of 200 training associates by eight, with this year being the largest class yet.
- The Public Health Law Program (Matthew Penn) provides internal to CDC and external partner technical assistance and evaluation.
- Rural Health has been successfully adopted by OSTLTS as a primary interest. We continue to gather data on the role CDC plays in rural communities, which is garnering great interest from the White House. The Appalachian region now has a Public Health Advisor and a dedicated PHAP Associate to assist with Shaping Our Appalachian Regions (SOAR) Initiative.
- The State Innovation Model Initiative's work is progressing by engaging states in networking phone calls to address the population health challenges they face and brainstorming ways to further help them. The central challenge is finding sustainable funding. A future 'lessons learned' webinar is being planned for December.
- The Tribal Action Council had a successful tribal support meeting and has finally filled each seat on their committee. There has also been an increase in direct funding to the tribes and, as a result, they are endeavoring in many promising projects.

Office of Associate Director for Policy (OADP)
Dr. John Auerbach gave an overview on the OADP work on collaboration with the health care sector. Responding to 4 key trends related to access to care, payment reform, delivery system reform (shift to patient center medical care home) and reduced resources for public health, the office is focusing on three buckets of work: Traditional Clinical Services; Innovative Clinical Services; Community-Wide Approaches. Examples of efforts:
- State Innovation Model (SIM) (which requires population-health strategy)
  - Collaboration of public & private payers working to align measures and incentives, with 34 currently funded states.
- 6/18 project strategically targets 6 high cost & high prevalence conditions with 18 evidence-based clinical interventions.
  - The development of a strong evidence-based approaches "in payer language" is in progress.
  - Working on a parallel project for community population-based interventions
  - Will address SDOH and include Health Equity
  - Goal is to create practical tools that could be used in tandem with value-based approaches to address specific conditions
- Working to identify examples of best practices where other states have successfully used health care money to support community-based interventions and will share these best practices in tool kits and models.
- CDC's Community Health Improvement Navigator (CHI-Nav) tool created as a tool for non-profit hospitals required under the Affordable Care Act to conduct Community Health Needs Assessments (CHNAs).
  - Emphasis on addressing SDOH in communities rather than solely on clinical care
- Promoting the Health Department of the Future with SDOH in the DNA of public health

<u>Questions/Comments</u>
- Tribal representation on STLT Subcommittee
  - ➢ Tribal reps struggle to have consistent representation at the STLT Subcommittee. OSTLTS will explore options such as: identifying a member of the Tribal Advisory Council (TAC) to act as a liaison to the STLT Subcommittee, or perhaps trying to schedule a TAC meeting adjacent to the STLT Subcommittee meeting.
  - ➢ John Weisman: In Washington State, the tribal representatives are included in our state meetings and we make it a priority to ask them how programs will specifically impact them.
- John Auerbach: the CDC Policy Office has a Community Navigator website to assist with ACA funding and is in the process of building a '**best practices' library**. When we find a program that is having some success with implementing a community-wide approach, we have conducted site visits to learn their strategies (ex: Oregon's Medicaid Initiative linking comprehensive care and community health). In an effort to build the evidence-based best practices in the community toolkit, we are also sharing the community-wide approach criteria with other CIOs in CDC and asking if they are aware of any evidence based programs showing quick results. The target date for sharing this library of programs is early 2016.
  - ➢ Action Item: During next TAC call, raise the question of awareness of any programs using a community-wide, evidence based approach for further discussion.
- Umair Shah: Dr. Frieden's Health Impact Pyramid seems to show social determinants of health (SDOH) at the bottom instead of showing how it relates throughout the entire pyramid. Even with the 6/18 Project, SDOH seems to be categorized separately. **Health Equity and social determinants of health principles** should be integrated into all aspects of addressing all diseases, not a separated activity.

Public Health Surveillance Think Tank Report
Terry Allan provided an overview of the previous day's Public Health Surveillance Think Tank meeting deliberations and the suggested recommendations for the STLT Subcommittee to consider sending to the ACD. To set the stage, he asked Chesley Richards to provide an update on previously adopted ACD recommendations:

1. *Recommendation supporting implementation of the CDC Surveillance Strategy specifically indicating that CDC should*
   - *NOT significantly modify or change the plan for at least 2 years to ensure progress and consistency in implementation*
   - *Ensure that the CDC Surveillance Strategy work is connected to existing efforts defining the Health Department of the Future and healthcare/public health integration*

- The surveillance strategy is formed around a framework with 4 parts:
  1) Culture: needs to change to improve the availability and timeliness of surveillance data
  2) Governance: needed to identify and amend or retire ineffective or redundant surveillance systems
  3) Technical Adoption: needed to advance effective use of emerging information technology
  4) Workforce: needed to maximize effectiveness of resources, and performance and coordination of surveillance systems

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Progress on Surveillance Strategy:
- CDC Surveillance Leadership Board has been established consisting of CDC leadership and with various sub-groups and provides guidance in addressing long standing governance issues to evolve a more consolidated CDC surveillance enterprise.
- CDC Informatics Innovation Consortium has supported 14 projects across CDC programs to spur informatics innovation, particularly in developing shared services to support CDC scientific programs.
- CDC based HHS Entrepreneur in Residence (EIR) has successfully been launched and worked on advancing electronic death reporting initiative, with two additional EIRs being recruited for the coming year for National Electronic Disease Surveillance System (NEDSS) modernization.

- o Faster availability of mortality data -- transferring mortality records to NCHS within 10 days (an increase from 12% of states in 2012 to 50% of states in 2015). We have seen that influenza mortality reporting is timelier with electronic data and adoption of this new system that allows departments to discontinue using outdated ones.
- o Transforming notifiable disease reporting:
  - Completed development of message mapping guides to update electronic messaging (replacing 20 year old electronic messaging software) for over 90% of notifiable disease data (which includes 5 million reports to CDC each year)
  - Implementation in the field – rolling out in late 2015 through 2016
  - Challenge is getting electronic message mapping out to all states, tribes, territories, and local health departments.
- o Electronic Lab Reporting Increase: 69% of lab reports to states are now electronic reports. Negotiations with Quest Laboratories to implement company-wide electronic messaging in 2016
- o Syndromic Surveillance:
  - Over 2,000 reporting facilities now cover 50% of all emergency department visits in the current BioSense/National Syndromic Surveillance Program
  - Implemented recommendations to establish baseline percentages and outlying performance goals to measure representativeness of hospital emergency data submitted to the National Syndromic Surveillance Program (NSSP) BioSense Platforms
  - Performed pilot project and developed implementing plan for enhancing BioSense platform by adding SAS software services and the ESSENCE syndromic surveillance software
    - Implementation of ESSENCE software offers opportunity for collaboration with DoD in utilization of BioSense platform for DoD syndromic surveillance needs
  - Challenge is we don't have the analytic tools for local health departments to do sophisticated analysis. As a solution, we are putting SAS into the electronic cloud for local departments to access.
2. *Recommendation that CDC should formalize a roadmap process for adoption and implementation of harmonized data standards within 16 months. The roadmap should:*
   - o *Balance flexibility and prescriptiveness in harmonizing standards*
   - o *Consider the role of funding in supporting use of harmonized standards*
   Progress:
   - Discussions are ongoing on Roadmap for Harmonized Data Standards: with key partners to identify the best format for including input on harmonization from STLT partners. An intergovernmental advisory council is under consideration.
3. *Recommendation that CDC should support development of a workforce plan for public health informatics and surveillance and should consider including:*
   - o *Training for existing workforce as first priority*
   - o *Expanding workforce for skillsets that do not exist*
   Progress:
   - A draft workforce plan has been developed
   - Analysis is underway: CDC workforce needs on surveillance, informatics and data science
     - ➢ May serve as a potential guidance for further work with partners on broader STLT workforce issues in these areas.
     - ➢ Challenge is training will not be sufficient if the organization can't hire the staff and/or retain them.
4. *Recommendation that CDC should formally endorse an approach that would decrease: surveillance systems, requested data from States, and duplicative information channels. To that end, CDC should:*
   - o *Transition from many siloed surveillance systems to fewer multifunctional systems by developing a policy on discontinuing duplicative, redundant surveillance systems creating a review process for programs that wish to create an individual, siloed surveillance system.*
   - o *Work with public health departments to develop a cloud-based and flexible IT platform to improve public health surveillance*

Progress
- A second report to Congress on these issues is drafted and in clearance
- Surveillance strategy activities on these issues are underway
- Discussions with and support of the ASTHO Public Health Community Platform are also continuing

Terry Allan led the subsequent discussion reviewing the previous day's Public Health Surveillance Think Tank meeting along with the group's recommendation focused on Electronic Case Reporting (eCR).
- <u>New Recommendation 1</u>: CDC should convene partners for a national strategy for Electronic Case Reporting (eCR).
    - o Include electronic health record (EHR) vendors, state and local public health officers
    - o Create a common path forward on achieving successful eCR
- <u>New Recommendation 2</u>: CDC must develop an ongoing financing strategy for the nation's public health information infrastructure by mid-2016
- <u>New Recommendation 3</u>: CDC must immediately implement innovative strategies to enhance the public health informatics workforce within CDC and throughout the public health system through new recruiting, development, and retention approaches.

Questions/Comments
Chair Jewel Mullen opened the floor for any questions or comments:

- James Gillan: Where are the opportunities for technology?
    - ➤ Chesley Richards: Health Departments will have the capability to do this if HHS gets behind this effort and pushes the vendors. In the past, all funding has gone to clinical interventions and not to electronic record implementation. The challenges are:
        - ▪ Getting everyone on the same standard for eCR
        - ▪ Vendors are multi-state entities with varying state rules to abide by, so the conditions for developing the electronic case reporting tool would have to be uncomplicated. Developing a national model for case reporting is not a viable option. We will have to create an agreed upon cohesive case reporting standard.
- Chesley Richards: We will also need to consider a link system to ensure local health departments are not detrimentally affected.
- Jose Montero: Referencing New Recommendation 1, how do we engage the payers with data and use the case reporting definition with a social determinants lens?
- Chesley Richards: There isn't a good answer to this question, but it does need to be part of the dialog. Public Health case reporting hasn't been categorized in this way.
- Julie Morita: New Recommendation 1 is a great idea. Our experience in Chicago was with the pharmacy and we are currently working on a small electronic case reporting pilot project with sexually transmitted infections. A national standard would help complete the data.
- John Auerbach: The usual correlates for social determinants with payers don't capture everything (like housing, SES, race vs ethnicity) and incomplete data is useless. Some efforts to do case reporting by zip code exist, but that data mapping isn't very useful. The challenge is determining where the valuable data is and how best to use it.
- Chesley Richards: Not all broad definitions are equal for notifiable diseases.
- David Fleming: This could be read by the public as CDC is responsible for providing the financing. This is a global, state, local, tribal, and territorial responsibility. Perhaps we should modify the language to specify which parties are responsible for funding.
- Chesley Richards: Funding would be generated from recommendation 1. Recommendation 2 could also come from a broad set of partners but we must recognize that some of the work will not be funded, which leads into workforce capability issues.
- Georgia Heise: Who is included in 'vendors?' Are we working with the current system already in place or building a new system?

- Chesley Richards: This would be specifically for Electronic Health Record (EHR) vendors and maybe one day expanding to other technical vendors. For EHR vendors, their focus is clinic records and they see CDC as asking a big ask to build one system. We would need to have a conversation of how this could be built on existing systems while taking into account individual local and state needs.
- Julie Morita: CDC needs to convene a group to see how recommendation 1 can fund recommendation 2.
- Mary Currier: Recommendation 1 can include the two groups (not sure if she means NEDSS, NCHS, Quest Labs, Biosense/national syndromic surveillance program, essence/DoD??) that were named and ensuring they feel engaged in the process.
- David Fleming: A combination of recommendations 1 and 2 makes more sense, but needs clarification of intent and language.
- Chesley Richards: In the past, CDC has convened a Blue Ribbon Panel on biogenetics to develop a funding stream. This might be a solution and could be a way to include a broad range of partners.
- John Weisman: For Recommendation 3, do we have an adequate workforce from which to recruit? Do we need to include numbers and consider the private sector salary scales?
- Chesley Richards: We can go back and modify the language to include partner outreach.
- Umair Shah: Comprehensive data is the key to surveillance. In Texas, we are trying to figure out how to do a statewide surveillance system without losing the local data. This is something to consider as CDC builds a forward path.

Jewel Mullen suggested postponing a vote on the public health surveillance recommendations until the Think Tank could revise their proposed recommendations, based on input.

Social Determinants of Health Think Tank Report
Dr. Jose Montero provided an overview of the Social Determinants of Health Think Tank's discussion and recommendations from the previous day's meeting. The group defined CDC's role in Social Determinants of Health as "enhanced capacity of CDC, STLT public health jurisdictions and health system partners to identify and address social determinants of health (SDOH) to improve population health.

- The goals are:
  - Long-term: social norm change where social determinants are part of the fabric of CDC programs, policy and research at the level that is appropriate
  - Mid-term: CDC initiatives incorporate social determinants in their work using a consistent framework with consistent, consensus-based definitions
  - Short-term: STLTs and health system partners are able to access and analyze non-health data sources for better understanding of full context of health conditions impacting population health
- The key objectives of SDOH at CDC include:
  - Raise awareness about relationship of SDOH to health outcomes
  - Inform practice to address SDOH
  - Inform policy that can impact SDOH
  - Increase ability to assess trends in SDOH at STLT and national level
  - Contribute to evidence base on impact of addressing SDOH on health outcomes
- Progress and Opportunities - Raising awareness on SDOH
  - Examples of progress include 'Did You Know' newsletter (May and August 2015); Special Supplement on Health Equity in Journal of Public Health Management and Practice (December 2015);
  - CDC-wide website on SDOH (soon to be published) will be a one stop shop for SDOH resources and tools at CDC and will include 4 sections:
    1. Data Sources on Social Determinants of Health
    2. Tools for Putting Social Determinants of Health into Action
    3. CDC programs addressing SDOH
    4. Policy options that can impact SDOH
  - website url: www.cdc.gov/socialdeterminants

- Progress and Opportunities to Inform Practice in Addressing SDOH
  - Building Leadership
    - CDC Leadership meetings – January and October 2015
    - STLT Leadership
      - Health Officers (e.g., multi-sector collaboration, PH department as convener; marketing role of other sectors in promoting PH, etc.)
      - New Health Official Orientation
      - Project Officers supporting STLT Grantees (TASII)
  - Collaboration with ASH (Dr. Karen DeSalvo, Acting Assistant Secretary for Health)
  - Optional (modifiable) language in Funding Opportunity Announcement (FOA) Template under Cost Sharing section: "Applicant should coordinate with multiple sectors such as public health, transportation, education, health care delivery, and agriculture."
- Progress and Opportunities Inform Policy that can impact SDOH:
  - PolCon 2015 – Focus on Health Equity and SDOH-related Policy (October 1, 2015); over 350 attendees
  - State of Health Equity Forum – Focus on working across sectors on policy (October 15, 2015)
  - CDC Community Health Improvement Navigator to help hospitals meet IRS requirement (www.cdc.gov/chinav)
  - Health in All Policies Resource Center website - currently under development
- Progress and Opportunities to Increase the ability to assess SDOH trends: these are direct responses to STLT Subcommittee recommendations:
  - Identifying indicators of Health Equity for CDC (Spring 2016)
    - Purpose is to measure national trends over time
    - Indicators will be SDOH
  - Accessing non-health data on SDOH website
    - Multiple conditions and disease (e.g., Community Health Status Indicators, Vulnerable Footprints)
    - Disease categories (e.g., Environmental Public Health Tracking Network, Heart Disease and Stroke Atlas, NCHHSTP Atlas)
- Think Tank considered:
  1. What are the criteria for next efforts?
     - Does it focus on what public health agencies can do and what is within their authority (versus partners, healthcare, etc)?
     - Does it fit within what CDC can do?
     - Is it practical? (e.g., resource availability, staff availability, political will)
     - Does it link to existing CDC efforts/framework/mechanisms?
     - Is it impactful on health outcomes?
  2. What will success look like this year and beyond?

Discussion

- Would be helpful to know what we could learn nationally from CDC grant data. Are we looking at any meta data within programs CDC funds? Need to bring human social services agencies to the table and incorporate their thinking into the 6/18 project.
  - Ken Robinson did some work to help lead the discussion yesterday suggesting we look at sources of data in human service agencies
- Ken Robinson: From perspective of leading a health department, need to ask how PH agencies can better engage with the clinical services.
  - CDC and partners can help frame the expectations on how PH agencies might engage with non-health organizations/human services.

- o Should consider standardizing the approach to human services/non health partners and integrate our best practices;
  - o Need to help partners identify additional funding sources.
  - o Need to find ways to incentivize monitoring and measuring success?
  - o Need to proactively push for adoption of human service inclusion with SDOH lens engagement.
- Technical Assistance: What does this mean for SDOH work with Health Departments? We need to figure out role of HDs in education, housing, socio-economic status, employment. Chronic conditions need to be addressed at various levels. How do we look through a SDOH lens at all levels
- Jewel Mullen: The Think Tank might entertain a recommendation re: incorporation of SDOH measures in surveillance data. She mentioned that there are federal agencies trying to get some standards passed that will include data collection around race and other social determinants
- Comments from John Auerbach
  - o Agrees there are some ways to begin thinking about incorporation of SDOH data in surveillance
  - o Maybe be a challenge to incorporate SDOH into all CDC programs, considering how many there are but some parts of CDC (e.g., Chronic Disease Center, OSTLTS, OADP) are intensifying their engagement already with SDOH work.
  - o CMS is releasing an RFA re: accountable care communities which will provide an opportunity to demonstrate engagement with SDOH. CDC is working closely with them.
  - o CMS is interested in determining what SDOH indicators might be included in electronic health records.
  - o The ACC project is looking for best practices that can be replicated and will ask grantees to look at such issues as:
    - Does the plan provides resources to hire at practice level people who connect directly to the community?
    - Is there support for an interpreter (e.g., community health workers) who serve as liaisons between patients and providers and proactively think about emerging issues like housing;
    - Is cost sharing for prescriptions eliminated?
    - Others
- Julie Morita: Chicago is in process of developing plans that address areas like housing and transportation and how they impact health. CDC has an opportunity to develop this same type of relationship with HUD and DOT at the national level
- Question to explore: Does PH accreditation offer an opportunity to include SDOH engagement as they part of the process
- Umair Shah: CDC has an opportunity to support reaches into the community that may not seem health related, like housing. The question is, when doors are opened, what do we do with that opportunity? NACCHO's president also has issued a health equity challenge to its members.
- John Auerbach: these plans were developed in the national prevention strategy where most federal agencies will do what you suggested; as this recommendation gets developed, we can further flesh this out.
- David Fleming: CMS concept – to what extent might this be a useful concept internal to CDC? To what extent does CDC do case management in respect to SDOH, like homeless person spreading infection because of homelessness?
  - o John Auerbach: CDC did case management in a comprehensive way, but we could survey the extent in which it's done. The challenge is focus on issues that identify the need but doesn't address them, which has limited value. We hear this all the time from local and state levels.

The challenge is getting the healthcare system to pay for more and pushing the healthcare boundaries to refer more patients. Shifting the cost from public health system to healthcare system is also a challenge. We need to think more globally and not create situations where the need isn't addressed.

- Jewel Mullen: This gives us a greater opportunity to figure out how to grapple with the current system.
- Umair Shah: Opportunities for other agencies to reach out to state/local agencies; there are some opportunities in the global sector that have tried to integrate across the system (in Europe) so we need to look at what they've accomplished and maybe get some ideas from them.
- Judy Monroe: One recommendation could be to tie in SDOH with accreditation and it might help push us at CDC.
  - o Georgia Heise: PHAB domains do cover a portion of this in accreditation; health depts. don't have the money to do extra SDOH management; if we have the workforce and pay them for clinical services, then that's what they will do.
- James Gillan: if you look at the Scandinavian system where they help fund healthcare, you would have to give up 60% of income. So, we would have to demonstrate that we can deliver what the expectation is. In the territories, we have a limited amount of money to work with and some programs are just out of reach and cost prohibitive. We have to get the policy makers to put up the money to even make a dent.
- Mary Currier: Look at HIV and how we've addressed these issues in the past as an example of how to move forward.
- Judy Lipshutz: Region V (CoIIN) score card might be a tool that health departments that can't go through the accreditation process could use.
- Jose Montero: On the next SDOH call in December, we will further address these challenges. The Social Determinants Think Tank members will continue to discuss which recommendations to endorse over lunch and present them to the subcommittee after lunch.

Public Health Finance Think Tank Report

Dr. Craig Thomas, Director of the Division of Public Health Performance Improvement, provided an update on the Finance Think Tank's accomplishments and their recommendations. He was reporting on behalf of Terry Cline, Think Tank Chair, who resigned from the STLT Subcommittee prior to this meeting. Dr. Thomas introduced two colleagues from who have worked with him and the Think Tank: Roberta "Bobbie" Erlwein and Liza Corso.

The charge for the Public Health Finance Think Tank 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. To advance this purpose, public health departments and programs must be fully accountable and transparent about their investments and accomplishments.

The accomplishments of the Finance Think Tank over the last year include:
- Served as a forum for discussion and input on a range of public health finance topics
  - o Title X funding
  - o Ebola supplemental funding
  - o CDC's 2015 report to Congress on options for aligning funding strategies based on burden of disease
- Provided ongoing support and guidance to CDC on the implementation of the 2015 public health finance recommendation previously adopted by the ACD
- *Recommendation 1: to improve the accountability and transparency of the Preventive Health and Health Services (PHHS) Block Grant, CDC should:*
  - o *Develop a plan to measure progress and impact of the PHHS Block Grant*

- o *Communicate current PHHS Block Grant achievements*
- o *Strengthen CDC business practices and administration of the PHHS Block Grant*

Progress: "Develop a plan to measure progress and impact of the PHHS Block Grant"
- o Conducted a rapid assessment of Block Grant Management Information System (BGMIS) funding allocation data
- o Planned exploratory analyses to:
  - Assess the role the PHHS Block Grant funds play in addressing public health needs and in supporting HP2020 objectives
  - Examine the relationship between patterns of funding allocations and program outcomes
- o Initiated design of a framework to articulate measurable program outcomes
- o Funded NACDD and ASTHO to support implementation of the FY 2016 evaluation strategy, including stakeholder engagement

Progress: "Communicate PHHS Block Grant achievements"
- o Developing and disseminating grantee specific reports by December 2015 with each report including:
  - A summary of program wide investments by HP2020
  - Grantee specific investments by HP2020 topic area
  - A success story highlighting grantee activities and accomplishments of the PHHS Block Grant

Progress: "Strengthen CDC's business practices and administration of the PHHS Block Grant
- o Impact and timing of process changes:
  - Fourth Quarter funding was released in August 2015 with no duplicative efforts for grantees or CDC
  - Compliance visits initiated during 1st and 2nd quarters
  - Detailed planning for FY17 implementation of additional changes to improve continuity of funding for grantees and further reduction of administrative burden for CDC

- *Recommendation 2: In the next 12 months, CDC should conduct an assessment of the factors and strategies that support the financing of foundational capabilities:*
  - o *Monitor current and new external initiatives that support the definition, costing, and implementation of the foundational capabilities*
  - o *Summarize the status of the work, including barriers and possible near-term and long-term strategies for supporting foundational capabilities*
  - o *Identify opportunities within CDC for financing the foundational capabilities (or the concepts represented in the foundational capabilities)*

Progress: "Monitoring and involvement with current initiatives"
- o Selected key efforts
  - RESOLVE Public Health Leadership Forum
    - FPHS Framework and definitions
    - Cost Estimate work underway in multiple states
    - Chart of Accounts
  - Public Health National Center for Innovation (PHNCI) – pending work through PHAB
  - Diverse state activities (e.g., WA, OH, OR, TX)
- o Continuum of Activities – for the different efforts (state, national, etc) there are differences in approach and focus, but with all focusing on some aspect of work in the following continuum
  - Concept/Overall Framework: development of framework
  - Definitions – determine the elements of foundational capabilities
  - Methodology – determining methodologies to assess costs/expenditures
  - Estimate Development –determining the costs by working with the field
  - Implementation/Use – how the foundational capabilities can be used or implemented
- o Update on related CDC Activities – CDC has done a lot to participate in and advance the work. We do have a white paper that summarizes the current status and opportunities for CDC, which has been shared and discussed within the think tank. Key areas of progress include:

- ▪ Crosswalks of foundational capabilities, accreditation, and HP2020 objectives
- ▪ Advancing awareness and dialogue around foundational capabilities
  - • Webinars, presentations
  - • Inclusion in guidance document provided to PHHS Block Grantees
- ▪ Exploration of opportunities and strategies
  - • New funding ideas, catalyzed by opportunity in FY16 President's Budget
  - • Strategies for future possible consideration
- ▪ Continued involvement / monitoring of national / state efforts – work continues to mature

Questions/Comments
- • Craig Thomas: These activities represent a large body of work and represents more than 2 years of progress. Since the finance think tank is in transition, this could be an opportunity to reconstitute the work if the subcommittee would like to go in a more specific direction.
- • Georgia Heise: We need to keep a supportive but close eye on the need for costing of public health and defining the practice of public health. This is the place to say this is who we are and the work that we do. We in Kentucky have tracked the cost of foundational capabilities and it is within the budget and that needs to be shared, that it is doable.
- • David Fleming: Given the momentum behind this and the role of the PHAB Public Health National Center for Innovation, we might consider how can continue to advance the recommendations and support of foundational capabilities within CDC.
- • This think tank was supposed to be time limited, but it shouldn't be sunset because its members together provide unique value and can talk in a non-vested way on a range of financing issues. This think tank is a place to entertain those issues.   There are still highly contentious issues between states, especially around rural health, and this think tank is a non-partisan way to discuss those issues.
- • Jewel Mullen: This think tank was established to help smooth over those issues and the Block Grant could be used to address and fund foundational capabilities.
- • David Fleming: There isn't a right answer. The finance membership can rotate to give continuously fresh ideas. We can have ad hoc meetings for those issues that form quickly and the group could respond quickly to allocating resource. Maybe having a standing group to meet to deal with these issues is a better solution than disbanding the think tank.
  Julie Morita: It's important to have an infrastructure in place to address finance issues. I like the idea of rotating members as it could help to educate members if they were rotated regularly.
- • James Gillan: Finance in public health will always be a challenge. Maybe we could have an ad hoc task force to address emerging issues, and if we find that there is a need to have a standing group because these issues will not go away, we can establish one.
- • Georgia Heise: The think tank has value in making big issues into digestible and easy to understand formats.
- • Craig Thomas: If the think tank does continue, we will need a new chairperson. If the think tank is disbanded, we will continue to provide updates on current recommendations in play. We will send David Fleming the recommendation documents (since they haven't been presented to the STLT Committee yet) for further reading.
- • David Fleming moved to continue the PH Finance Think Tank with a second from Georgia Heise. Vote to keep this think tank was unanimous.   John Wiesman volunteered to join the PH Finance think tank, including serving as its chair. Terry Allan volunteered to participate as well. The current members will

try to recruit other members outside the STLT Subcommittee. Jewel Mullen suggested including someone who isn't in a state that is involved in foundational capabilities work to get fresh ideas.

Public Health Surveillance Think Tank Recommendations

Dr. Terry Allan presented the final Public Health Surveillance Think Tank Recommendations. We need to think about how we move the surveillance process forward and create some context for electronic case reporting that will lead into the recommendations.

Context: Why Electronic Case Reporting (eCR) Matters:
- More complete, accurate data in real time for action
- Vastly improves detection of outbreaks
- Early detection of cases allows for
  o Earlier intervention
  o Diminished transmission of disease
  o Protects the broader public
- Directly links healthcare to population health
- Acting now leverages Meaningful Use 3 incentives
- Responds directly to the needs of local and state partner needs

Revised Recommendation: By Mid-2016, CDC should convene appropriate partners to develop recommendations for:
- A national strategy for electronic case reporting (eCR) and
- Identifying the resources to support the required eCR and related infrastructure, prospectively;
  o Resources include financial, workforce and technical capabilities
  o Examples of partners include
    - relevant federal partners - ONC, CMS, DoD, HRSA
    - state and local health departments
    - EHR vendors
    - healthcare organizations
    - allied associations – CSTE, JPHIT, ASTHO, APHL, NACCHO

The timeline allows us to strengthen partnerships and can influence the new administration as they come in.

Discussion on proposed recommendation
- David Fleming: How is this recommendation for eCR different or the same as the previous recommendation?
  ➢ Chesley Richards: We are putting together a background slide to further flesh out the previous recommendation. This recommendation is an extension of the previous one and doesn't reset that these initiatives aren't important, but rather trying to get to a lower burden system. The previous work continues and a goal aimed at 2018 for a national goal.

ACTION: Jewel Mullen moved for a vote to endorse the Public Health Surveillance Think Tank recommendations. David Fleming gave the motion and Jose Montero seconded the motion. The vote was unanimously approved.

Public Health Associates Program (PHAP) Think Tank Report
Georgia Heise introduced the discussion about deliberations and recommendations for the Public Health Associates Program (PHAP). She introduced Heather Duncan, PHAP Director, who provided an update on program progress.

The purpose of the PHAP Think Tank is to advise CDC on ensuring the sustainability and quality of PHAP so it meets the current and future needs of public health. The PHAP program started in 2007 and now supports 330 associates, the majority of whom are placed in state and local health departments. In 2015, non-governmental agencies were added as host sites. The associates are learning in the field and contributing to the public health.

The Think Tank proposed that CDC identify "no color" funds to ensure the financial sustainability of PHAP and conduct workforce analysis aimed at developing a strategic workforce plan that includes the number of associates needed by STLT agencies and CDC

OSTLTS, through the Applied Systems Research and Evaluation Branch of the Division of Public Health Performance Improvement, oversees PHAP evaluation focused on a wide range of key outputs and outcomes related to quality, effectiveness and impact.

- The quality indicator for enrollment -- # of qualified applicants hired into PHAP is particularly pertinent to a discussion about sustainable funding for the program. The cost of the program is directly related to the size of the class. This year, the incoming class size is 208. Noted is that a discussion of class size should directly relate to workforce needs (or gaps).
- Currently, there is no workforce analysis or plan to help inform data-driven decision making for PHAP class size, but we are currently discussing what the needs are around this program.

Questions/Comments
- Georgia Heise: My experience with this program is that it does provide value and provides associates with ways to experience different areas of public health. This group should lend our support to this program.
- Umair Shah: We've had some PHAP placements recently and this program is important for both local- and state-level support. It also should help shape the potential workforce, providing greater understanding of what public health practice really means. We want to make sure that PHAP is sustainable regardless of who the CDC director is (since Dr. Frieden has been very supportive).
- James Gillan: We had one placement and she was outstanding. These associates bring fresh ideas and our PHAP associate was able to reenergize the folks that had been in Guam.
- John Weisman: In reference to the number of associates needed, how do you get to this number since agencies could use multiple associates? Has there been PHAP graduate feedback to better refine the training program? What other workforce recommendations are out there and how does this fit into workforce development?
- David Fleming: I'm concerned that this program might be associated with a certain CDC director. Can we endorse this program to CDC internally? Can we include this as a recommendation at the ACD? Does the program currently have any flexible funding?
  - Heather Duncan: OSTLTS has funding which is flexible for up to 75 associates per year. There is a concern about taking categorical money for use in the program. This past year, we were no longer able to ask CIOs what they wanted to contribute, but had to tell them the amount they were expected to contribute. We would like to return to a model of asking programs what they need.
  - Judy Monroe: If the categorical agencies put in for an associate, the PHAP has to work in that category. But if the flexible funding is used, the associate can go to any field.
  - Judy Monroe: We have a set number that's been set for us by Dr. Frieden. The CIOs are very supportive of this program. The tension comes when CIOs are being told that we need this certain number to support this program.
    - ➢ We don't know the right class size in relations to what the needs are in the field.

- ➢ We also would like to know the needs in the STLT community for specific areas like informatics
- Julie Morita: Thanks for the program. We should as group endorse program and focus on 2nd recommendation with reformed funding and do workforce analysis to demonstrate the value of the program.
- Jose Montero: Who does workforce analysis and what's the framework? What's the context? What type of workforce are we trying to develop? The flexibility in these positions is key because they can be innovative and can be placed in human services or informatics, which would be innovative. Would this be part of the framework, and if not, can it be?
- Judy Monroe: In the last few months, we have been on the phone with Duke University. They wanted to see how our PHAP program is structured because they are finding that these students are hot tickets for medical school. Hospitals are also interested in paying for part of the program because they see the value in the experience the associates gain. This program is getting life of its own because of the changing healthcare climate.
  - o Jose Montero: These students are the field workers that can transition from public health to healthcare delivery and human services.
- Terry Allan: Is there room to chew on this for a while? Is there a model for this evolving need? Can these students become embedded at the various levels on specific issues? Can we pilot this to become a part of the workgroup in a specific state and to address specific issues? This could bring back some relevant context.
- Umair Shah: We need think about where we do have flexible funding and how those funds can support the more innovative health departments.   This may help CDC with the stratification piece and who should go where. An example would be health equity as it may be a good fit for this type of stratification.
- Question: Can CIOs provide "no color" funds?
  - o Answer: No, they are typically categorical

ACTION: Group voted unanimously to endorse continuation of the PHAP program. Noted:
1. This is an endorsement without specifying the number of needed associates
2. The method for coming up with the number of associates was imprecise.
3. Should come back to this discussion with a number based on workforce analysis

- David Fleming: Suggested striking recommendation re: "no color" funds and add a recommendation to develop a funding strategy. In this process, we need to look at the existing opportunities and workforce training opportunities.
- Umair Shah: It's okay to maintain the current number and then define the workforce development piece and how this will fit into the broader strategic workforce plan.
- Julie Morita: There are different training programs. Do CIOs contribute to those, too?
- Judy Monroe: We set up the PHAP Leadership Board recently. Maybe they should take up this challenge and define a workforce development plan and take this beyond OSTLTS.
- James Gillan: If there are 200 associates per class, we need to look at 200 of what "type" of worker is needed (e.g., informatics, etc.)Jewel Mullen: Does this lead us to a workforce recommendation to the ACD? Moving towards sustainability without declaring a number? Are we recommending that a workforce analysis be done? Does this need to be across CDC?
  - o Yes to all the above.

- Judy Monroe: Concern is whether this a quality program with this number of associates. Do we need to put in some language around quality or do you need to see more quality analysis first (internal to this STLT Subcommittee)?
- Andrea Young: We have a lot of quality data and will be happy to share more if you need to integrate this into the language.
    - Julie Morita: it would be valuable to read, but it's not needed to endorse the program right now.
    - CDC will send out these materials
- Umair Shah: We all seem to have anecdotal comments of the program's value, but do we need to have more information to make an endorsement for the overall program.
- Judy Monroe: Yes, we can look at quantitative data and can discuss further in the next meeting. There is some tension within the CIOs around the size of the program.
- David Fleming: Can we call an ad hoc meeting if need to before the next class selection?
- John Weisman: We need to have more dialog around workforce development and look at what support is actually needed.   I don't feel like we're ready to make a recommendation.
- Terry Allan: Many public health departments haven't recovered from their recessionary loss of staff and see PHAP as helpful for help in filling these losses.

Jewel Mullen: Am I hearing that we shouldn't put in a number of associates, but should endorse and continue to work on appropriate language for workforce strategy?

ACTION: The STLT Subcommittee agreed unanimously to propose a recommendation to the ACD regarding strategy and workforce development that involves the PHAP level. Language will be refined to reflect wishes of this subcommittee for presentation to the ACD.

Social Determinants of Health Think Tank: Consideration for Recommendations to the ACD

The STLT Subcommittee considered some draft language for making SDOH-related recommendations to the ACD for their consideration. However, it was concluded that there was more work to do to refine and further discussion is needed. The SDOH Think Tank will meet to discuss further options and report back at the next STLT Subcommittee.

Public Comments

Jewel Mullen requested that lines be opened for public comments. There were none.

Concluding Reflections

- Jewel Mullen: Think Tanks are functioning well and will continue their work and will shape deliberations for upcoming meetings.
- David Fleming: Because I was a member of the committee since the early inception, I want to encourage us to take time in agenda planning to think about what else is out there to consider. Thanks to all for your continued hard work.
- Terry Allan: Next time, consider having think tanks meet in the morning to allot more time in preparation for STLT Subcommittee meeting.   By having the think tanks in the afternoon, we didn't have time to wordsmith. Maybe we should consider having a working dinner to allow us to continue wordsmithing for the next meeting.
- James Gillan: It takes 18 hours to travel here for a one day meeting but it is worth it because it helps me see how public health policy work gets done and gives the territories a voice at the table. I also get a better sense of what the public health needs are.

- Mary Currier: I think it's important that everyone stays engaged in the issues and I learn so much by being at these meetings because we all have different needs.
- Georgia Heise: It's great to learn from other public health rock stars.
- Julie Morita: I enjoy learning from others in the public health field and dialoging about key issues. I would like to perhaps join a think tank, too.
- David Fleming: We are fortunate to have this type of dialogue and learning opportunity.
- John Weisman: ditto what David Fleming said.
- Terry Allan: I find the conversations very reaffirming in dialoging through issues.
- Jewel Mullen: I really want to learn more about what's going on in my state and have been talking with them about foundational capabilities. This body helps me do my job better and I appreciate that.
- Judy Monroe: Thanks Jewel for being the new chair. I appreciate the fact that this group doesn't just rubber stamp the issues and recommendations. Thanks to Judy Lipshutz for her diligence and attention to the details and to OSTLTS leadership and to the staff for facilitating a great meeting.

Meeting adjourned at 3:20 pm