



Minutes from the
October 14, 2015

CDC Advisory Committee
to the Director
Health Disparities
Subcommittee

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Advisory Committee to the Director Health Disparities Subcommittee Record of the October 14, 2015 Meeting

The Centers for Disease Control and Prevention (CDC) convened a meeting of the Health Disparities Subcommittee (HDS) of its Advisory Committee to the Director (ACD) on October 14, 2015 in the Global Communications Center on the Roybal Campus, Clifton Road, Atlanta, Georgia. The agenda included updates from the Office of Minority Health and Health Equity (OMHHE), discussion of progress on the HDS Recommendations to the ACD, discussion of HDS priorities, discussion of social determinants of health (SDOH) work at CDC, and a presentation and conversation with Dr. Jonathan Mermin, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).

Roll Call / Welcome / Overview of Meeting

Leandris Liburd, MPH, PhD, Designated Federal Official (DFO), Health Disparities Subcommittee (HDS), Director, Office of Minority Health and Health Equity (OMHHE), Centers for Disease Control and Prevention (CDC), called the meeting of the CDC HDS of its ACD (ACD) to order at 10:05 a.m. on Thursday, October 14, 2015.

Ms. Gwen Baker, Program Specialist, OMHHE, CDC, called roll and established that a quorum of HDS Subcommittee members was present in person and via telephone. Quorum was maintained throughout the duration of the meeting. The new and returning HDS Subcommittee members introduced themselves and their professional and research focus areas. A participant list is appended to this document as Attachment #1.

Lynne Richardson, MD, FACEP, Chair, HDS Subcommittee welcomed the subcommittee members and commented on the talented and diverse group that had assembled to move the issue of health equity forward, finding opportunities in public health practice and policy to give support, suggestions, and guidance to CDC to ensure that the agency's work is as effective as possible in promoting the cause of health equity.

OMHHE Updates

Dr. Liburd welcomed the new and returning members of HDS emphasizing that they reflect the depth and breadth of knowledge, experience, and energy that will support OMHHE and CDC's work in the arena of health equity. She then presented updates from OMHHE.

At the end of 2013, OMHHE expanded to include the CDC's Diversity and Inclusion Management (DM) Program and the agency's Office of Women's Health (OWH). These additions accompany OMHHE's Minority Health and Health Equity (MHHE) Teams. The office continues to grow, and will add its first Associate Director for Communications (ADC), who will help accelerate the dissemination of OMHHE's work in language that is more accessible to the public and to colleagues.

As part of OMHHE, OWH will continue its mission of promoting the health of all women. There are opportunities within OMHHE for OWH to be equally concerned about improving health outcomes for women of color and other women who experience a greater proportion of poor health outcomes and health disparities. The DM Program is more internally driven and has four priorities that reflect the need to ensure that CDC has a workforce that is reflective of the nation, including 1) Recruitment; 2) Retention; 3) Succession Planning, creating career ladders so that a diverse workforce is prepared to assume leadership roles in the agency; and 4) Performance Management Assessment Process (PMAP) priorities, as PMAP has revealed disparities in how people are rated and the distribution of those ratings across the agency.

A diverse and high-performing workforce will contribute to CDC's ability to address health disparities in more targeted and impactful ways. The MHHE aspect of OMHHE is continuing its work. Health equity is an overarching umbrella under which women's health as well as diversity and inclusion find a place.

This year was the fourth of CDC's Undergraduate Public Health Scholars (CUPS) program. In 2015, there were 171 students from throughout the country who were assigned to one of four grantees:

- Columbia University, New York City, New York
- Kennedy Krieger Institute, Baltimore, Maryland
- University of Michigan, Ann Arbor, Michigan
- Morehouse College, Atlanta, Georgia

Over 12,000 students have applied to CUPS since the program began in 2011. Of the applicants, 755 have been selected for the program. In fiscal year (FY) 2016, the process of writing the new Funding Opportunity Announcement (FOA) will begin so that CUPS can continue. The expected award date is August 2016.

HDS submitted recommendations regarding social determinants of health (SDOH) through the ACD. Strong focus on SDOH continues across CDC. Collaboration with the State, Tribal, Local, and Territorial (STLT) Subcommittee of the ACD is an important element of this work. OMHHE; the Office for State, Tribal, Local and Territorial Support (OSTLTS); and the Office of the Associate Director for Policy (OADP) have been working together to achieve better coordination and more focus on SDOH throughout the agency. Two meetings in 2015 assembled senior CDC leaders to discuss SDOH within the agency. OMHHE continues to serve as CDC's lead office for the Healthy People (HP) 2020 SDOH topic area. The HP 2020 SDOH framework guides CDC's continued development in this area.

In May 2015, OMHHE released on behalf of CDC the agency's first *Vital Signs* report on Hispanic health. The issue has had tremendous reach, with over 48,000 downloads in English and over 37,000 in Spanish on MedLine Plus, and over 18,000 English downloads and over 19,000 Spanish downloads on Hispanic American Health. Within 30 days of the release of the report, over 900 news articles referred to it. This report holds a record for all *Vital Signs* reports released by CDC of having reached an estimated over 1.7 billion people. The week prior to this HDS meeting, the two lead authors of the report participated in a Congressional briefing hosted by the US Senate Republican Task Force on Hispanic Affairs.

In 2011 and 2013, CDC released the "CDC Health Disparities and Inequalities Report (CHDIR)" [MMWR, October 7, 2011 / Vol. 60 / Supplement / Pg. 1 – 124; MMWR, November 22, 2013 / Vol. 62 / Supplement / No. 3 / Pg. 1 – 187]. In addition to systematically describing the burden of health disparities and inequalities periodically, OMHHE decided also to highlight CDC's efforts in response to the burdens. The first *Morbidity and Mortality Weekly Report (MMWR): Strategies to Reduce Health Disparities* was released in 2014 [MMWR Supplements, Vol. 63, Supplement, No. 1, April 18, 2014]. The issue included five interventions that met criteria regarding strong quantitative outcomes and experience to meet the standard of not only reducing health disparities, but also evaluating impact.

The 2016 report on strategies for reducing health disparities is being prepared for release. Some of the report will be presented in commentary format, as these articles are not typical for *MMWR*. A great deal of the work is innovative and represents shifts for CDC. The table of contents for the report is:

- Foreword
- Background and Rationale
- Commentary – “Traditional Foods Have Become a Way to Talk about Health”: Native Communities Reclaiming Traditional ways to Promote Health and Help Prevent Diabetes
- Living Well with a Disability Self-Management Program
- Adaptation and National Dissemination of Brief Personalized Cognitive Counseling
- Evidence-Based HIV Prevention Intervention for High-Risk Men Who Have Sex with Men
- The HoMBReS and HoMBReS Por un Cambio Intervention to Reduce HIV Disparities among Immigrant Hispanic/Latino Men: Reducing Risk and Developing Community Capacity
- Progress toward Eliminating Hepatitis A Disease in the United States: Disease
- Prevention as a Path to Health Equity
- Preventing Violence among High-Risk Youth and Communities with Economic, Policy, and Structural Strategies
- Use of Evidence-Based Interventions to Address Disparities in Colorectal Cancer Screening
- Boston Children’s Hospital Community Asthma Initiative (CAI): Tackling Health Disparities with Improved Pediatric Asthma Outcomes
- Epilogue

The commentary on American Indian foodways describes a program that is still being evaluated and that incorporates land use and sovereignty. The report also includes a piece on a disability intervention, two HIV prevention interventions, and a paper on hepatitis A that demonstrates “closing the gap” for vaccinations. Other pieces address reducing violence among high-risk youth in communities with economic policy and structural strategies, colorectal cancer screening with outcomes driven by community health workers, and an innovative asthma initiative in Boston that combined collaboration with a hospital and environmental changes. The *MMWR* and subsequent reports will contribute to the literature to demonstrate that it is possible to reduce health disparities.

The release of the special issue of the *Journal of Public Health Management and Practice (JPHMP)* on the science and practice of health equity is planned for December 2015 and will be dated January 2016. CDC has been involved in health equity and SDOH work over a decade, but the agency has not necessarily committed lessons learned and perspectives from this work to the literature. In collaboration with the Association of State and Territorial Health Officials (ASTHO), CDC embarked on this project to articulate as well as possible, given the evidence base, the science and practice of health equity. The guest editors for the supplement are: Dr. Leandris Liburd; Dr. Maureen Lichtveld; Dr. Ed Ellinger, the Minnesota State Health Officer; and Dr. Ulene Lao, a medical epidemiologist with the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).

The table of contents of the supplement is as follows:

- Editorial: Leandris Liburd, PhD, MPH
- Editorial: Paul Jarris, MD, MPH – ASTHO Perspective

- Commentary: Shiriki Kumanyika, PhD, MPH; President of APHA
- Commentary: Health Equity and Public Health Ethics: The Need to Develop a Robust Concept, by Dr. David Goldberg
- Trends in Disparity by Sex and Race/Ethnicity for the Leading Causes of Death in the United States: 1999-2010
- Differences in Chronic Disease Behaviors by Sexual Orientation and Sex
- Measurement for Action to Advance Health Equity
- Toward Achieving Health Equity: Emerging Evidence and Program Practice
- Policy Approaches to Advancing Health Equity
- Sustaining a Focus on Health Equity through Organizational Systems and Functions
- Integrating Vertical Equity into a Public Health Funding Strategy
- State and Territorial Infrastructure for Health Equity and Minority Health
- Role of the SHO in Elevating and Promoting Health Equity in All Policies in Minnesota
- Balancing Tribal Sovereignty and the Role of Inter-Jurisdictional Partnerships in Oklahoma
- Promoting Health and Behavioral Health Equity in California
- Commentary: Health Equity Research and Recommendations of the Health Disparities Subcommittee
- Editorial: Barbara Ferrer, PhD, MPH

The descriptive epidemiological paper from NCCHSTP utilizes Asians as a reference group. The descriptive epidemiological paper on differences in chronic disease behaviors by sexual orientation and sex is based on data from the Community Transformation Grant (CTG) project. Four papers have emerged from the State of Health Equity at CDC forum series and address measurement that informs health equity indicators, the essential design elements within public health interventions and programs that should be considered to advance health equity, policy, and the infrastructure needed within CDC to advance health equity. A paper from the Division of Cancer Prevention and Control (DCPC) describes a method for making funding decisions that respond to the burden of the problem. ASTHO is providing an analysis of a survey of state offices of minority health that was conducted in collaboration with the US Department of Health and Human Services (HHS) Office of Minority Health (OMH). From Minnesota, a paper addresses the role of the state health officer in promoting health equity. A paper from Oklahoma focuses on working with tribes to advance health equity, and a paper from California addresses behavioral health equity. A commentary from HDS Chair Dr. Lynne Richardson describes policy opportunities and recommendations from HDS. Dr. Barbara Ferrer has contributed an editorial on racism and the Kellogg Foundation's work regarding racial healing. The intended use of the supplement is to inform work across CDC and within the broader public health community.

Three years ago, Oxford University Press asked Dr. Liburd to create a bibliography on health disparities. The bibliography was released as of August 31, 2015. It is framed around SDOH and includes sections pertaining to what works to reduce health disparities. Because it is web-based, the bibliography can grow. A subscription is required to see the entire bibliography.

The US-Brazil Joint Action Plan to Eliminate Racial and Ethnic Discrimination and Promote Equality (JAPER) project has been in existence since 2008. OMHHE became involved in JAPER on behalf of CDC in 2011. They have worked with colleagues in the Office of Global Affairs (OGA) at HHS as well as with counterparts in Brazilian government. An in-person meeting is being planned in collaboration with the Pan American Health Organization (PAHO) for December 2015. Two webinars will be held in October and November 2015. JAPER has presented opportunities for OMHHE and CDC to share lessons learned regarding reducing

health disparities. OMHHE is learned from Brazilian colleagues regarding their approaches to these issues and to workforce development.

The fourth annual State of Health Equity at CDC Forum will be held on Thursday, October 15, 2015. The title of the forum is “The Power of Policy: Working Across Sectors to get to Equity.” The 2016 forum will focus on infrastructure. Another strategy will be implemented to keep the issue of health equity front and center at CDC. Close to 150 participants have registered for the 2015 forum.

OADP and the CDC policy community held their first “PolCon” on October 1, 2015. The event convened approximately 350 participants to discuss policy issues at CDC. OMHHE participated with a health equity track. There is a great deal of excitement and energy associated with OMHHE’s work with OADP.

Discussion Points

Regarding CUPS, Dr. Ro asked about the possibility of expanding the number of university grantees.

Dr. Liburd replied that with additional resources, it would be possible to include more grantees.

Dr. Lichtveld offered her congratulations for the *Vital Signs* report and noted that she was proud to have been at its unveiling as part of the Hispanic-Serving Health Professions Schools (HSHPS) Workforce Committee. She hoped to feature the continued utility and visibility of the report as part of an HSHPS newsletter.

Dr. Ro congratulated Dr. Liburd and OMHHE on making rich contributions to the literature. Regarding the journal article that will use Asians as a comparison group, she expressed her hope that the recent dialogues on Asians as a “model minority” were taken into account. A commentary reflecting Asians as a group, and disaggregating Asians and Pacific Islanders, would be welcomed. There are considerable disparities within the sociopolitical grouping of “Asians.” She also expressed hope that the article would not perpetuate the myth of the “model minority.”

Dr. Liburd said that there have been conversations on this issue. While the paper does not disaggregate Asians by subgroups, the choice for conducting the analysis should be clear in the text.

Dr. Ro said she understood why the analysis would be conducted in that way. There is a strong, organized Asian American health movement that has tried to advance understanding of the reasons behind the aggregate numbers. In reports that she generates, it is noted that there are disparities within the Asian category, specifically among Southeast Asian Americans. Including that note can make a major difference when Asians are used as a comparison group.

Ms. Wilson indicated that in her previous position, her group was examining Census data for their service area. The American Indian/Alaska Native and Native Hawaiian or Other Pacific Islander populations were extremely small at all four of their hospitals. There was a tendency to think that the populations were not important because they were so small; however, the utilization data showed over 1500 encounters with individuals from the Guamanian or Chamorro population. Census data from the county only indicated 53 people who identified as such.

Dr. Ross asked about access to the Oxford University Press bibliography. Dr. Liburd replied that individuals or institutions can have subscriptions to the Oxford University Press resources. Dr. Richardson noted that schools of public health often have subscriptions, as the resources are frequently utilized by students.

Dr. Liburd said that the bibliography was developed for an audience of upper-division undergraduate and graduate students as well as anyone desiring a broad overview of health disparities.

Dr. Ro encouraged working with publishers to create opportunities, even if they are time-limited, for individuals in communities of practice to access these rich resources for free. For instance, depending on the status of a health department, local public health practitioners may not have access unless they have connections to academia. If these resources are to have widespread use and distribution, they must be affordable. Even if the bibliography is low-cost, the literature to which it refers is extremely costly.

Dr. Richardson commented that this might be an area for a proposal to a foundation to fund such access.

Dr. Lichtveld asked for additional detail about the CUPS program, including how other universities and groups can be eligible.

Dr. Liburd replied that the CUPS program has a fulltime evaluator. The program is doing what it was intended to do. Broad goals are provided to each grantee institution.

Mr. Julio Dicient-Taillepierre leads the team that focuses on the rollout of the funding initiative that supports CUPS and the evaluation efforts of OMHHE as well as individual grantees' evaluations of their activities. The evaluation process is in the formative phase, and strong program evaluation data have been generated. Some of the analyses will be made available to the public after a review by the Office of Management and Budget (OMB). Additional outcome-oriented evaluation of the program will be conducted. Each CUPS grantee has been encouraged to utilize innovative approaches to ensure that they have targeted approaches to reaching a diverse set of all students who are interested and available to apply to the program. Students from all racial and ethnic categories have applied and been accepted to the program. A targeted and intentional approach is applied to ensure that students who represent racial, ethnic, and other sociodemographic minority characteristics are aware of the program and have an opportunity to apply and be accepted to it. There has been a representative cohort of students in each year of the program, using Census data as a reference point. The program has been engaged in discussions with grantees regarding their recruitment and promotion efforts to ensure that students across the country are aware of the program and are able to apply.

Dr. Lichtveld asked about the kinds of projects the accepted students work on and about whether/how the students are followed on their trajectory to a graduate level. She further asked whether evaluation occurs at the student, grantee, and program levels.

Mr. Dicient-Taillepierre replied that the program is evaluated at all three levels. OMHHE evaluates CUPS at the program level. Grantees are involved in evaluation of their activities and of students. OMHHE is preparing an OMB package to conduct more extensive follow-up evaluation of individual students. A foundation of data for this work is available. They are in the process of ensuring that the foundation data are valid and can be built over time.

Dr. Liburd explained that each grantee can accept up to 50 students. The students indicate their interest in minority health issues during the application process. The grantees select the students, who spend 8 to 10 weeks working on a public health activity with the grantees. The students accepted by Morehouse mostly come to CDC, either in Atlanta or at a facility in Morgantown, West Virginia; Cincinnati, Ohio; or Washington, DC. The Kennedy Krieger students are in Baltimore, Maryland; Los Angeles, California; and South Dakota. The goal of the program is to expose the students to public health, and they complete a public health project. They are mentored by staff at the grantee institutions and are encouraged as they progress toward careers in public health. Graduates of CUPS are frequently accepted by CDC's competitive Public Health Associates Program (PHAP). CUPS contributes to a diverse public health workforce that is committed to addressing health disparities.

Dr. Lichtveld commented on the growing stream of schools of public health that offer Bachelors of Science degrees in public health. These programs include requirements for capstones and projects that include community service hours.

Mr. Dicient-Taillepierre pointed out that CUPS reaches out to students before they have even considered public health as an area of interest. The outreach incorporates disciplines outside public health or traditional allied medical health areas. A disproportionately larger group of students is already interested in public health or medicine, but students who have never considered public health are important. The outreach design also includes students who have completed two years of community college and who are contemplating a four-year degree. OMHHE also collaborates with the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) on the James A. Ferguson Infectious Diseases Fellowship, a graduate program that tracks students after they complete it. OMHHE also has a Memorandum of Understanding (MOU) with HSHSP. Each of these programs connects students with a mentor, as data indicate that the mentor relationship is sustained beyond the program period. Grantees collect contact data on students, and they are tracked for a minimum of two years. Those data are helping in preparation for the next FOA.

Dr. Lichtveld asked about the public health workforce development aspects of JAPER and whether they focus on research and practice or only on practice.

Mr. Dicient-Taillepierre answered that from the beginning of the program, Brazil has been interested in workforce across sectors, including the policies that drive reductions in racial and ethnic discrimination in health; the workforce structures and policies that drive strategies; pipelines; and examples of programs that have helped to reduce the discrimination that racial and ethnic minorities may face in healthcare settings. The program is broad, and CDC's collaboration has been more explicit by focusing on key areas to start dialogue.

Dr. Garza said that CUPS is an excellent program. She asked whether the next FOA would be competitive among current grantees and whether additional grantees might be added.

Mr. Dicient-Taillepierre said that depending on the availability of resources, the next FOA could go in a number of different directions. They are still in a process of negotiation. The main goal is to continue the program.

Dr. Richardson acknowledged that details of the OMB process could not be revealed and asked whether there is a possibility that CUPS could be reduced in scope and size.

Mr. Dicient-Taillepierre said that there is commitment to continue the program at the current level. OMHHE hopes for more resources, as the program is clearly successful and data are available to demonstrate that success.

Dr. Lichtveld asked for clarification regarding whether the FOA will be competitive, or whether it will award the same four grantees if the resource level is unchanged.

Dr. Richardson replied that this question is still under consideration. If more resources are available, then an open announcement will be required to fund additional grantees. If the program were in danger of being reduced, HDS might want to weigh in to encourage expansion of the successful program.

Dr. Ross felt that HDS should weigh in on this issue. One of the charges to the Coordinating Council on Public Health is to address the issue of workforce diversity and to consider outcomes. With its documentation of outcomes, it is likely that the Coordinating Council would be supportive of CUPS.

Mr. Dicient-Taillepierre reported he made a presentation to HDS when the CUPS grantees were initially funded. He suggested making a presentation to HDS summarizing the data that were collected and analyzed over the five years of the program at a future meeting.

Dr. Richardson indicated that HDS would appreciate that presentation.

Ms. Ryder appreciated the focus on tracking and data analysis and looked forward to hearing reports. She suggested examining a specific impact measure over time in order to address not only outcomes, but also long-term impacts of the program. If a goal is to increase diversity among the professional workforce at CDC, for example, it would be interesting to know how the CUPS program affects that goal. She also asked about efforts to maintain contact with the large number of individuals who were interested in and applied to the program, but who were not accepted. Perhaps contact could be maintained with the applicants through ongoing dissemination of information. Even if they were not accepted into the program, they made the effort to apply and have interest in these issues.

Mr. Dicient-Taillepierre replied that the process of determining a benchmark indicator of success for grantees, beyond nominal performance expectations, is ongoing. Because CUPS is a program FOA, such a benchmark has not been defined or made explicit. OMHHE has utilized an intentional approach of collaborating with grantees and discussing these issues throughout the program. All of the CUPS grantees met with OMHHE over a three-day period in the summer of 2015 to examine the data and discuss what the data illustrate. Each grantee has chosen a specific publication topic. Discussions are ongoing regarding what CDC and the grantees want to convey about the program. This work is part of conversations with the Coordinating Council, as this effort should harmonize with the Council's work and with communication with HDS. He hoped for feedback regarding measures for success. Further, following students who are not accepted into CUPS is a resource issue. A good portion of resources are devoted to maintaining students who have completed the program. They are aware of and interested in following students who applied to CUPS but were not accepted, even to learn whether they apply again the next year. This work is beyond their current resources, but they would be interested in doing it in the future.

Ms. Ryder suggested that the CUPS application form could ask whether an individual is applying for the first time. She also suggested that social media mechanisms could be utilized to create opportunities for those with retaining interest in these issues to have access to information or links to databases and other resources. Such a social media link would enrich the workforce, which could self-select.

Mr. Dicient-Taillepierre indicated that the question is included on the application form. OMHHE is engaging in more social media work beyond passive promotion. The grantees have created YouTube videos about their programs. Resources are still a concern. Social media is a workload-intensive activity. Those efforts depend upon what the grantees are willing and available to do. It is a “labor of love” that is beyond their expectations and is not analyzed rigorously.

Mr. Fukuzawa asked whether the selection of the four grantees was competitive, and whether there is private support for the program.

Mr. Dicient-Taillepierre answered that the selection was competitive. While OMHHE had been engaged in pipeline programs for some time, they wanted to take a more rigorous and monitored approach to the work. Even as the office’s budget was reduced, CDC Director, Dr. Tom Frieden, earmarked funding from the CDC Office of the Director for CUPS. The program represents a shift from several different pipeline grants to a single program.

Dr. Lichtveld commented on the tremendous disparity in the academic workforce as well as in the practice workforce. Junior scholars struggle as they rise in tenure rank. There is “bunching up” at the Assistant Professor and Clinical Professor levels. The higher in rank, the less the representation from diverse populations. The earlier the workforce strengthening efforts begin, the better. She proposed that HDS review the CUPS program in great detail during a future HDS meeting.

Dr. Richardson agreed and noted that Mr. Dicient-Taillepierre offered to provide HDS with a summary and data about the program.

Dr. Lichtveld said that the field knows of new, innovative models that work. For instance, her group works with high school students and tracks them through college. CUPS should be the best it can be.

Regarding private support for CUPS, Dr. Liburd indicated that OMHHE is in discussions with the CDC Foundation on this topic. The foundation would be the venue by which the program could garner private resources.

Update: Progress on HDS Recommendations

Dr. Richardson reminded the group that ACD approved a set of recommendations from HDS in 2014 that provided guidelines for how CDC can address issues of health equity more effectively and successfully. Since ACD’s approval of the six recommendations, a number of initiatives have been generated to address them.

Recommendation #1: Develop a CDC framework for action to achieve health equity.

Mary Hall, MPH, Associate Director for Policy, OMHHE, CDC, described a variety of ways in which OMHHE and CDC have been working on implementation and fulfillment of the HDS recommendations. The goal of having a framework was catalyzed by HDS. Two parallel

processes drive this work. First, the State of Health Equity at CDC Forums represent an internal engagement process with the wider CDC community. The following four forum areas form the outline for the framework structure:

- Measurement and monitoring of health equity
- Essential program elements of health equity programs
- Policy approaches or “levers” to support or achieve health equity
- Infrastructure

The four topics are also represented in four papers within the upcoming special supplement of the *JPHMP*. Each forum is the result of a year of organizing and working with internal groups across CDC. The upcoming forum on policy levers represents a broad spectrum of input from policy and health equity staff from the entire agency. It is geared toward CDC’s internal work to strengthen policy to support health equity.

The other parallel process for implementing the first research is the formal synthesis and articulation of the evidence base. This external approach through the special supplement of the *JPHMP* shares CDC’s four critical focus areas with the wider public health community. The supplement includes papers from the field to illustrate what the focus areas mean in practice. After the supplement is released, it and the State of Health Equity at CDC forums will launch the reconvening of cross-agency groups to synthesize a framework. The combination of external syntheses and internal processes will lead to the development of a CDC framework for action that will work for the agency and its partners. The draft framework will be vetted across the agency with a variety of mechanisms. The process will be shared with HDS.

Recommendation #2: Identify and monitor indicators of health equity.

Dr. Ana Penman-Aguilar, Associate Director for Science, OMHHE, presented an update on the second HDS recommendation.

The reviewers for the journal supplement requested specific examples of how CDC will apply principles of monitoring to its work. She had the opportunity to describe this recommendation and the work of HDS to the reviewers. In particular, she emphasized more complete reporting and paying greater attention to the fact that individuals live their lives with multiple identities, and there are multiple ways in which the different dimensions interact.

The *Vital Signs* focused on Hispanic health was an example of making the HDS recommendations “real.” It incorporated the intersections between Hispanic origin, US-born versus foreign-born individuals, into large tables. The report was a heavy lift and illustrates the importance of not looking at a population as monolithic.

To pursue implementation of the second HDS recommendation, a community of persons interested in the topic has been gathered from across CDC. They have scanned the universe of national initiatives, including policy links, to monitor health equity. The group has considered sub-national indicators as well. Ultimately, they are not trying duplicate efforts. Rather, they will focus on vibrant and alive initiatives such as HP 2020 and *CHDIR* as a starting point.

HP 2020 has a framework and objectives that could be considered as indicators. CDC might have unique needs for indicators that are not in that package, but any indicators that the agency creates should be complementary. The National Center for Health Statistics (NCHS) is collaborating on the first indicator, which focuses on workforce. Data sources for the indicator include labor surveys.

Recommendation #3: Align universal interventions that promote better public health, with more targeted and culturally tailored interventions in communities at highest risk to reduce health disparities and achieve health equity.

Mr. Dicient-Taillepierre provided an update on progress on the third HDS recommendation.

This recommendation is interlaced with the other HDS recommendations. Progress on the recommendation is an iterative process. The article on programs in the special supplement, which shares a title with 2014's State of Health Equity at CDC Forum, serves as the foundation for assembling resource material and fact sheets for internal CDC use on what is meant by a "health equity program." This definition has been challenging, and conversations about it are ongoing in many venues.

In particular, efforts to integrate health equity into CIOs' FOAs have presented conceptual challenges. Tying indicators to funding and grant cycles has been another challenge in the FOA process. Many of the co-authors of the supplement article are CDC partners who are working on the FOA language initiative.

OMHHE is holding a health equity workshop for the staff of NCCDPHP to unpack the notion of health equity in their work in advance of writing an FOA. A template has been created that all CIOs are required to use when they write their FOAs. OMHHE provided initial feedback and support to the development of that guidance in 2012. There have been annual updates to the guidance, and each update endeavors to strengthen the guidance that is specific to health equity. OMHHE is generating health equity reference material to support the staff who write the FOAs.

The work has been constrained because of the timeframe for releasing an FOA. CIOs typically only have an 8- to 12-month period in which the FOA is written, published, and awarded. Having discussions about foundational constructs and design at that time is too late. The upcoming health equity workshop represents the first time that these discussions will take place well in advance of the FOA writing process. The leaders of the workshop are the co-authors of the manuscript and several members of their health equity teams.

The expectation of the workshop is not to provide training on what health equity is; rather, it will help staff members think through what they are already doing, and how their efforts in health equity can be enhanced. They are the experts in their field, and OMHHE will provide technical guidance wherever it is needed. OMHHE hopes to provide additional similar workshops across the agency. NCCDPHP is heavily invested in health equity. It may be challenging to bring the workshop to other CIOs that may not see its value. The initial workshop will help build a solid product that can be shared elsewhere within the agency.

When the manuscript is published in the special supplement, the co-authors and the members of the FOA guidance team are poised to start meeting to discuss a framework for the alignment of universal and targeted interventions. Settling the definitional issues of what is meant by health equity is leading to conversations about universal versus targeted versus culturally competent interventions, and when it is appropriate or not to align them.

Recommendation #4: Support the rigorous evaluation of both universal and targeted interventions and, where indicated, the use of culturally appropriate evaluation strategies, to establish best practice approaches to reduce health disparities and achieve health equity. All programs and initiatives should devote resources for rigorous evaluation to determine the health equity impact.

Dr. Liburd reported that Craig Wilkins is leading the progress on the HDS workforce recommendation. He is working with CDC University on the process of creating a curriculum. Additionally, they will request an audience with the Public Health Accreditation Board (PHAB), which has a health equity component. It will be important to work with PHAB to share findings to inform the accreditation process. OMHHE has also pursued a Learning Institute at the American Public Health Association (APHA). Such an effort would incorporate all of CDC's health equity and SDOH resources into a one-day training. OMHHE is also working closely with the ASTHO president regarding the challenges of attaining optimal health for all and advancing health equity. These efforts are examples of how OMHHE will push health equity work to the established CDC and public health workforce. Work with the workforce pipeline will also continue. They hope to garner additional resources for the Millennial Health Leaders Program, which focuses on graduate public health, public policy, and medical students. The students are sponsored by their university to participate. The partners include Harvard University, Brown University, the University of North Carolina at Chapel Hill, and Princeton University.

Ms. Hall added that OMHHE is looking at internal offerings for CDC staff and grantees, recognizing that external opportunities are available. Some of OSTLTS's partnerships are related to this recommendation. OMHHE representatives recently met with the leadership of PHAP, a CDC program that places staff at state and local health departments. OMHHE is considering opportunities to provide health equity content and to supplement their training with health equity training opportunities to infuse health equity into their work at state and local health departments.

Discussion Points

Recommendation #1

Dr. Richardson asked about the process by which the final, clearly articulated framework for action will be formally adopted by CDC, and whether there are examples of other trans-agency frameworks.

Dr. Liburd said that this kind of work is somewhat decentralized and takes place at the level of the CIOs. OMHHE is housed in the Office of the Director (OD) and has been intentional about not conducting its work independently from the CIOs. If the framework were slated for publication, it would progress through the layers of CDC clearance, which include the individual centers, the Office of the Associate Director for Science (OADS), OADP, and peer review, with comments from each. If the framework remains internal, the CIOs will tailor the framework for their work. That work relies upon the leadership within each CIO and their ongoing collaborations with OMHHE.

Dr. Ro appreciated the work that is required to lay the groundwork for the framework and to create it. She encouraged CDC to consider the timeframe, however, given that the 2016 election cycle has begun. Achieving a framework as early as possible in 2016 will be important so that the legacy of HDS's work is cemented and retained at CDC.

Dr. Lichtveld wondered how internal and external uptake of the framework could be monitored quantitatively. The current climate presents opportunities to select concrete examples of what works and to encourage their funding. A package with internal and external examples of data could make these concepts "real."

Dr. Liburd said that the content of the journal supplement will guide the creation of program guidance for the FOA template. This internal work is concrete. OMHHE is working with CIOs regarding these concepts and how to judge incoming applications according to the criteria. OMHHE is also working with CDC University to develop a course to target managers and project officers. The content from the journal supplement will inform the design of this course. OMHHE will be available for ongoing technical assistance.

Dr. Lichtveld commented that PMAP can be helpful in assessing contributions to the framework, both in individual performance assessment and program-level or office-level performance assessment.

Ms. Hall said that the first HDS recommendation is linked to the subsequent recommendations for which systems are in place to track shifts associated with the framework. The tracking takes place in one way for monitoring systems, for example, and in another way for the FOAs. It is a good suggestion to coalesce the different systems into a single monitoring strategy for the overall impact of the framework.

Dr. Garza found the prospect of a course through CDC University to be exciting. Her institution has a Community Health major with over 500 students. Opportunities to share cutting-edge frameworks are welcomed. She hoped that access to the course would be open so that it can be implemented or utilized in coursework.

Ms. Ryder observed that the intersection between public health and community health is closely tied to population health. She suggested that they think about an additional pipeline of the individuals who are currently employed in more than 1200 community and migrant health center corporate entities. These people are from different disciplines and backgrounds, as well as ethnicities. To the extent possible, they should be offered opportunities to participate in the class to make the most of that intersect.

Recommendation #2

Dr. Lichtveld asked about the timing for the workforce indicator.

Dr. Penman-Aguilar hoped that monitoring could begin in the spring of 2016 to begin building a report.

Ms. Thompson expressed her excitement about the endeavor, which is needed in the field. She asked about the degree to which people actually engaged in this work would be involved in measurement.

Dr. Penman-Aguilar said that OMHHE's connection to Policy Link is an important resource. She hopes to utilize the connections of HDS members as well.

Dr. Garza noted that the effort complements the workforce indicators and objectives of HP 2020. She asked whether the work aligns with the workforce development section of the Affordable Care Act (ACA).

Dr. Penman-Aguilar said that she would crosswalk their work with the ACA. They have focused on the health and healthcare domains of HP 2020, and progress cannot be made in that area without better workforce representation.

Dr. Ro said that they should consider their strategy as performance measures and reports are created. One strategy could focus on sharing data to catalyze action. Another strategy could link performance measures to programs, policies, and services. CUPS is one of the founding bodies of work of OMHHE and could be a way for OMHHE to have influence on CDC as a whole. The ability to use data to drive action is difficult. She was pleased that OMHHE is hiring a Communications Officer. HDS developed the recommendations so that they will lend themselves to the strategies and framework that shape how OMHHE will make a difference.

Dr. Liburd noted that OMHHE has had to build a great deal from the ground up. If they do not meet a degree of rigor, their initiatives will not move forward. They are a small office that has invested in "heavy lifts" given the resources available to them.

Dr. Ro emphasized that while OMHHE is small, it has growing influence, which is exciting. It is important to stay focused on the principles of equity that underlie all of their work. Because resources are limited, they should be used in ways that are most impactful.

Dr. Penman-Aguilar emphasized that in many ways, Dr. Liburd has "broken the mold" for the type of work that CDC does. *MMWR* is open to the ideas and perspectives of the community, which is a result of building reputation and relationships. As indicators are being developed, there is a balance between having the necessary information to understand the conditions in the US that drive health, and accountability. The first indicators will include CDC's footprint; that is, areas where CDC can do something. Discussions regarding the workforce indicator have focused on what to do with CDC data on diversity. There is room for the indicator to hold the nation, CDC, and OMHHE accountable.

Dr. Lichtveld pointed out that CDC was a major leader in workforce development 15 years ago, and that work can be built upon. At that time, the team developed a framework to consider workforce development quantitatively as well as qualitatively. The framework was used by the Institute of Medicine (IOM) in their report "Who Will Keep the Public Healthy: Educating Public Health Professionals for the 21st Century." At the time, that work was connected to the creation of Section G of the Bioterrorism Act, when every state health department had funds to build workforce capacity focused on bioterrorism. Programs were funded with ASTHO, the National Association of County and City Health Officials (NACCHO), and the Council of State and Territorial Epidemiologists (CSTE).

Dr. Ross reflected on the interconnectedness of the HDS recommendations, stressing that they are not stand-alone. Workforce diversity relates to the concept of the Coordinating Council, which includes a range of relevant stakeholders. Working with the council will allow OMHHE's work to spread further.

Recommendation #3

Mr. Fukuzawa asked whether the difficulties were associated with the value of health equity, how health equity is operationalized, or both. He wondered how HDS could elevate the issue.

Mr. Dicient-Taillepierre replied that most of the difficulties are related to how to operationalize health equity, but the value of health equity can also be a challenge. Those who struggle with the value of health equity wonder why “health equity” is a concern as opposed to another term or concept. He hears questions regarding whether health equity is a foundational premise or whether another concept or term could be used. This reaction has been observed in the strategy meetings for FOAs. The reaction is not because people do not feel that health equity is important; rather, they are gauging how much can be done given current resources and capacity. People try to understand how to operationalize the implications of health equity in terms of understanding the data that they have, the quality of data that they have, infrastructure capacity, how funding is awarded, and other issues. The changes feel like a significant, structural paradigm shift. In the strategy meetings, OMMHE offers to provide assistance to begin the process. There is no report card or performance benchmark to meet, but each program can have guidance to address health equity in some manner. Programs typically ask for examples of how to implement health equity. The rigorous work done by OMMHE has led to helpful examples, such as small-scale, low-cost, focused approaches that can help centers think about health equity. Not all centers have the same resource levels or structural supports. Some CIOs are experiencing a deep learning curve as they are new to these issues, while other CIOs have been doing a great deal of work in these areas. For instance, the Care and Prevention in the United States (CAPUS) Demonstration Project is an example of CDC’s collaboration with other federal agencies to examine SDOH to address racial and ethnic disparities and to support the National HIV/AIDS Strategy. The FOAs are written in conjunction with other federal agencies so that the language matches and so that the policy implications of each FOA within each federal agency complement each other. This work requires strategic collaboration across sectors as well as advance time and preparation. Ideally, each of CDC’s CIOs will work across disciplines and sectors. Reaching this goal requires a staged approach to encouraging CIOs to think about what health equity work means for them.

Dr. Richardson applauded the work of Mr. Dicient-Taillepierre, Dr. Liburd, and the rest of the OMMHE staff. She emphasized that every CIO should integrate health equity into everything they do. OMMHE cannot create or achieve this work alone. OMMHE is meeting each CIO where it is and helping it move forward. The work is labor-intensive and requires building relationships. She was not surprised that the work has begun with establishing definitions, as starting “where they are” sometimes means that “they are nowhere,” and so the work starts at the very beginning. This foundational work is important and must be done to move the concepts forward. It can be frustrating because it takes time to see output and progress, but the hard work must be acknowledged. She was interested in the order in which CIOs are being approached and asked if/how HDS can be helpful as a group or individually.

Dr. Lichtveld echoed the congratulations and recognized that the process can be difficult. Influence can be exercised at two levels. First, every FOA can include an agreed-upon statement that addresses health equity. Second, and more tangibly, the element of the FOA that addresses health equity can be incorporated into the evaluation criteria. The second step is more difficult, but it represents a win. The work relies on building relationships with friends and potential friends. The National Institute of Environmental Health Sciences (NIEHS) has a Research to Action grant that could be instructive, as it focuses on quantitative, data-driven findings while still utilizing community-based participatory research (CBPR). That grant can be shared with CIOs as an example of scientifically rigorous work in health equity.

Ms. Wilson thanked Mr. Dicient-Taillepierre and the OMHHE staff, noting that this work had advanced considerably since she, Dr. Horner Johnson, and Mr. Vargas began considering these issues as a workgroup of HDS. In their deliberations, they considered other agencies' work in health equity. For instance, the Substance Abuse and Mental Health Services Administration (SAMHSA) incorporates a Diversity Impact Statement and a variety of other tools into their grant mechanisms.

Mr. Dicient-Taillepierre indicated that he is working with the Associate Director for Policy regarding the process for including a similar diversity impact statement for CDC. The evaluation criteria for FOAs are also important. Including one standardized evaluation question in every FOA would be a significant milestone. OMHHE is also working on a policy statement regarding a standing CDC policy on language access and how to incorporate language access into funding grants and contracts and into the ways that staff are hired, trained, and certified, as well as into basic public health communication to the American public. The approach should be systematic.

Recommendation #4

Dr. Ro commented that the work is exciting. There are great opportunities to work across agencies. Disseminating the curricula to local public health entities could be enhanced by working with regional APHA offices. There may also be deliberate benefit in focusing on the bridge between public health and population management by working with the Centers for Medicare and Medicaid Services (CMS) regional offices. There is more focus on healthcare and less on population health, and an approach to health equity through a population health lens is important for other agencies to recognize. Local public health entities try to work with all agencies. The agencies can bridge connections to local entities around health equity.

Ms. Ryder agreed, emphasizing that healthcare without health equity is just "Band Aid medicine." Healthcare will continue to be provided, but change will not be created for the populations who are served unless health equity is embraced. For so many communities, health equity is tied to poverty. Combining healthcare with action-oriented interventions is challenging.

Dr. Lichtveld expressed hope that the curriculum would be competency-driven so that learners' knowledge, skills gained, and attitude can be measured. She suggested that the curriculum could be made eligible for Continuing Education Units (CEUs). She supported the idea of a Learning Institute. Connecting with PHAB is important, and it might also be helpful to work with the Council on Education for Public Health (CEPH), which accredits all schools of public health. CEPH is going through a revision of the core courses within the Masters of Public Health (MPH). The revision will focus on SDOH. OMHHE should be part of this process early on. The

HHS Regional Health Equity Councils (RHECs) are also working on similar issues and could be helpful.

Dr. Liburd said that an OMHHE representative participated in a recent RHEC meeting, which included all state OMH directors. They can work more closely to make a plan for engaging the regions to a larger degree.

Dr. Richardson noted that ACD has formed a workgroup on Healthcare – Public Health Collaboration. Some members of the group have been infusing equity and disparities into the conversations about the intersections of public health, healthcare, and population health. There have been interactions between CDC and CMS on these issues. All of these issues should be included in every forum, whether they are regional opportunities, cross-agency opportunities, or internal to CDC. It helps to identify allies who can help make the work more impactful.

Ms. Hall noted that OMHHE and OSTLTS have joined with CDC's Policy Office, which is focused on spanning public health and healthcare, to move SDOH and health equity forward. These connections are being made in different realms. The more they can work on these issues with other agencies, and within CDC, the stronger their products will be. OSTLTS is aware of the ongoing curriculum development.

Ms. Thompson suggested that in framing cultural competency, the term “cultural humility” ought to be embraced. “Competency” focuses on skills associated with culture, where “humility” ensures a lifelong pathway of understanding various cultures and their needs. Regarding work with other sectors to infuse health equity principles and values, she noted that people rarely disagree with the values of health equity. They do not, however, know how to translate their bodies of work into health equity concepts. It may be useful to craft guidance so that people can see where they are already engaged in health equity work, but may not have called it “health equity.”

Dr. Ross agreed and recalled HDS conversations about highlighting justice and peace to a greater degree across federal agencies. There is interest in creating common standards and language. He hoped to maintain a focus on these issues.

Social Determinants of Health at CDC

Judy Lipshutz, OSTLTS, CDC, described the STLT Subcommittee, which also reports to ACD. The STLT Subcommittee was created because of a desire to have cross-cutting relationships with state and local health department directors. The subcommittee identifies issues that are of concern at the local level, including SDOH. The subcommittee has Think Tanks that focus on specific issues. The subcommittee's work on SDOH has evolved from a think tank on that topic, and the subcommittee made recommendations to the ACD that were adopted regarding accessing non-health data sources, training, and other issues. The recommendations have grown into a larger body of work. The recommendations were attached to the HDS recommendations, and the two groups work closely.

Ms. Hall said that a group of CDC staff worked with the recommendations from the two ACD subcommittees to create a plan for how the agency can address SDOH coherently. The purpose of the plan is to serve any of CDC's partners and collaborators regarding SDOH, with the following goals:

- ❑ Long-Term Goal: 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 Goal: CDC initiatives incorporate social determinants in their work using a consistent framework with consistent, consensus-based definitions
- ❑ Short-Term Goal: 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 group defined the following key objectives associated with SDOH at CDC:

- ❑ Raise awareness internally about relationship of SDOH to health outcomes
- ❑ Inform practice to address SDOH
- ❑ Inform policy that can impact SDOH
- ❑ Increase the ability to assess trends in SDOH at the STLT and national levels
- ❑ Contribute to the evidence base on the impact of addressing SDOH on health outcomes

Ms. Lipshutz provided examples of how these objectives are being addressed. Regarding raising internal awareness, OSTLTS has utilized its weekly *Did You Know?* email publication to share information on the Community Health Status Indicators tool, which has been updated recently and includes a number of SDOH indicators by county. It is an important tool for identifying non-health data sources. Another edition of the email publicized the Community Health Improvement Navigator, which is geared toward hospitals and their community requirements.

The STLT Subcommittee recommendations referred to creating a CDC-wide website to consolidate the agency's resources related to SDOH. OSTLTS pulled information, products, guidance documents, policy tools, and other resources at CDC to populate the "one-stop shop" website, which will be published soon. The site will have four sections:

- ❑ Sources for Data on Social Determinants of Health
- ❑ Tools for Putting Social Determinants of Health into Action
- ❑ Existing CDC programs addressing Social Determinants of Health
- ❑ Using Policy to Impact Social Determinants of Health

Other SDOH activities focus on CDC leadership and STLT leadership. The agency reaches out to health officers in many ways, which will provide avenues for incorporating SDOH. An orientation is held every year for new health officials, and SDOH can be included in it. CDC program officers are trained to help their grantees better incorporate SDOH.

Ms. Hall noted that CDC's internal policy audience is reached by events such as PolCon 2015 and the State of Health Equity Forum. The health equity track at PolCon focused on intersectoral work related to SDOH and also addressed the National Prevention Strategy. Programs across CDC were invited to share examples of where policy plays a role in their health equity work. The State of Health Equity Forum addresses SDOH with agency employees that are engaged in health equity and also reaches a wider policy audience from across the agency.

The Health in All Policies Resource Center is an external website that will be published soon. It has grown out of CDC's National Prevention Strategy work, which sits within the Office of Policy. The website provides links to a range of internal and external resources for entities at all levels to engage in "health in all policies." The website is also a result of CDC's and HHS's collaboration with other departments on the National Prevention Council.

Regarding increasing the ability to assess SDOH trends, efforts are ongoing to identify health equity indicators for CDC that are linked to SDOH. The SDOH website includes a section on accessing non-health data and using it with health data so that communities and state health departments can build a better overall picture of health in order to set priorities.

HDS is a source of strong external support and recommendations. The input from HDS is invaluable, particularly regarding short- and long-term work in SDOH. Ms. Lipshutz said that the STLT Subcommittee SDOH Think Tank is another strong resource, and they discuss issues such as CDC's and public health's role in achieving health equity and ensuring that it is part of the fabric of public health. The STLT Subcommittee hopes to continue to collaborate with HDS, and one of HDS's former members, Dr. Jewel Mullen, is the chair of the STLT Subcommittee. A great deal of collaboration is ongoing among OSTLTS, OMH, and OADP regarding these issues.

The website will serve as a base and will grow in an iterative fashion as new ideas come to the forefront. It will be publicized via different avenues so that it will be used. Some strong materials and products have been developed, but they are not well-known. There is also growing interest from the State Innovation Model (SIM) states regarding SDOH. There are ongoing healthcare-related discussions about the services that should be covered and reimbursable. There are also questions about which areas of SDOH are appropriate for healthcare involvement. CDC is identifying ways to be involved with other sectors. The National Prevention Strategy is intended to be a cross-sector collaborative effort, for instance.

Discussion Points

Dr. Richardson concurred that HDS and the STLT Subcommittee should continue to collaborate. She suggested that an HDS member might sit on the SDOH Think Tank of the STLT Subcommittee.

Dr. Ro is from a SIM state and noted the importance of cross-sector collaboration. Regarding the health in all policies resource center and public health's core function of assessment, the LawAtlas allows for policy surveillance at the national and local levels. An assessment tool not only for creating good policy, but also for knowing what is missing in policy would be valuable.

Dr. Ross commented on opportunities for collaboration, particularly regarding the interface of public health and the health sector. Electronic health records (EHRs) represent an opportunity, as large healthcare corporations are revamping their EHRs and incorporating SDOH. The decisions regarding which SDOHs should be incorporated should be made in collaboration with STLTs and related organizations.

Ms. Lipshutz agreed. The Center for Surveillance, Epidemiology and Laboratory Services (CSELS) has growing interest in determining which SDOHs should be incorporated into EHRs. They are finding challenges given the large number of surveillance systems and in consolidating and harmonizing data, but they are interested in SDOH. CDC's policy office has done some of

this work with CMS and the SIM states. An IOM report identified EHRs as a point of interest as well.

Regarding EHRs, Mr. Fukuzawa said that the Kresge Foundation has been supporting work with the National Association of Community Health Centers (NACHC) on a risk assessment protocol, considering the IOM domains and all available evidence to connect specific determinants with chronic health conditions. The work is in the testing stage and eventually can be scaled up through the community center-controlled health networks to achieve 50% penetration when it is verified.

Ms. Lipshutz expressed interest in learning more and contacting persons involved in the work.

Ms. Wilson said that the final Stage 3 Meaningful Use Standards will be officially released on October 16, 2015. A draft of the standards is available. It refers to the collection of social, psychological, and behavioral health information as part of EHRs. It also requires vendors to collect and make available information on sexual orientation and gender identities, but providers are not required to collect the information. The information regarding race and ethnicity is more granular.

Dr. Richardson stressed that because these issues are interrelated, it is important to get into the conversation early. In her work with the Commission to End Health Care Disparities (CEHCD), she has observed interest from practitioners in the healthcare sector to access that data because it influences health. The structure of many EHRs does not include a field for some of the data that should be collected. If there is no demand for the fields, vendors will not include them. The work will require inclusion and regulations to move forward and collect more granular information on race and ethnicity, language preference, gender identity, and sexual orientation. Other fields are also needed, particularly to link EHRs to conditions for which determinants are influential.

Ms. Lipshutz said that discussions take place with CMS regarding what should be in the EHR. The Assistant Secretary for Health is also working on efforts to identify different social determinant indicators. If the work starts at that level, it might penetrate the larger system so that electronic health data systems will incorporate “the norm” at the CMS level.

Dr. Liburd indicated that the effort is in its early stages.

Dr. Ro commented that local public health does not have access to EHR data. If only 20% of health is dictated by healthcare, it is important to influence the other 80%. The challenge of partnering with other sectors, such as housing, on data is that those sectors would like to receive usable data from public health. Support and guidance is needed from CDC working with the US Department of Housing and Urban Development (HUD), the US Department of Education (ED), and the US Department of Labor (DOL). Without this guidance, the work cannot occur, as the regulations do not align. Partners will use health data as they need it, so it is important for the public health sector to understand the perspectives and approaches of those partners, which are different from the public health lens.

Ms. Hall said that Dr. Liburd is co-chair of the HP 2020 SDOH topic area. They have had conversations with HUD regarding sharing data, which is an important part of the difficult work of collaborating. HP 2020 offers CDC an opportunity to bridge multiple departments at a time. This work is ongoing.

Dr. Horner Johnson inquired about the availability of data for disability in relation to SDOH. She received an email indicating that the National Health Interview Survey (NHIS) is considering changing the way it collects disability data, only including disability questions for two years at a time and then removing the questions for two years. This change would have a great impact, as multiple years of data are often needed to secure a large enough sample size to assess issues related to SDOH. The comment period about this issue is open until the end of October.

Ms. Wilson said that the draft from May included disabilities, but she was frustrated because disability is considered under “function of life” as opposed to a demographic variable. Data are typically stratified by demographic information, so other elements could be buried.

Dr. Horner Johnson has also pushed for disability to be included as a demographic. The Behavioral Risk Factor Surveillance System (BRFSS) did make that change. The passage of the ACA was encouraging, but other data systems appear to be going backwards.

Dr. Richardson asked that Dr. Horner Johnson draft a short description of what has happened in the past, what is proposed, and what the impact might be. With that information, she can make inquiries at the ACD level on behalf of HDS.

Dr. Lichtveld said that EHRs can be geospatially linked with SDOH, particularly in defining the environment more broadly than the physical environment to include the social, policy, and other environments. Geospatial overlays bring meaning and reality to the concept of “where you live determines your health.” Additionally, there is significant support to link pediatric EHRs with what is referred to as “citizen science.” That is, linking the records with self-reported information in the Patient Reported Outcome Measurement System (PROMIS), a database supported by National Institutes of Health (NIH). The funding research regarding PROMIS focused on validating the database as a substantive component of the EHR.

Dr. Ross said that this work represents the forefront of the future of EHRs. The work may seem exclusively in the healthcare domain, but ultimately, citizens will be able to access their public health information from the public health sector. These ideas represent an exciting paradigm shift, and public health should inform the process as it diffuses out of the healthcare realm.

Dr. Liburd asked how these ideas are connected with the Precision Medicine Initiative (PMI).

Dr. Ross said that precision medicine will allow for the capture of genetic data to learn how individuals metabolize drugs and respond to treatment. Ultimately, however, precision medicine will move into the field of epigenetics, considering how environmental influences affect the genotype. The field of epigenomics has already been established to address the issue of moving precision medicine into the field of population health.

Dr. Lichtveld said that the exposome is well-known in basic science. She is working with a group to develop a conceptual model for the “public health exposome” that takes into account individual- and community-level interactions with the environment across the lifespan. She offered to share the paper with HDS, as it brings precision medicine into perspective.

Dr. Liburd noted that health equity is being invoked in the language regarding precision medicine.

Dr. Ross noted that the President’s State of the Union address rolled out \$200 million for the PMI. As the movement continues, the resources should be available to all in society.

Mr. Fukuzawa said that the science is developing rapidly and incorporates not only the larger environment, but also micro-environments. He wondered whether the Community Health Needs Assessments (CHNAs) being conducted by hospitals could result in usable data sets. As these data are collected repetitively, finer variations can be gathered.

Dr. Ro indicated that a number of groups are working on these issues. In Washington, DC, Academy Health has been funded, and she hoped to make connections with the groups doing this work.

Dr. Lichtveld said that the National Institute on Minority Health and Health Disparities (NIMHD) issued a U54 grant on precision medicine, which could represent translation of precision medicine “from the bench to the trench.”

Discussion of HDS Priorities

Dr. Richardson explained that HDS engaged in a priority-setting exercise in 2013. She led the group in a discussion of where the subcommittee should focus its efforts going forward and whether any issues can be closed out or need follow-up.

Priority #1: Examine opportunities to promote health equity through CDC Funding Opportunity Announcement (FOA) language

This work is progressing with Mr. Dicient-Taillepierre and his team at OMHHE.

Priority #2: Coordination of HDS/recommendation information across various organizations and advisory groups, including HHS Office of Minority Health Advisory Committee, IOM’s Roundtable on Population Health, etc.

CDC collaborates with other agencies and sectors, and HDS can engage in similar work at the advisory committee level to link with other advisory groups. The ongoing collaboration with the STLT Subcommittee of ACD is an example of internal work, but there may be other internal and external groups to work with.

Priority #3: Enhance training and composition of the public health workforce to:

- Address diversity of the workforce*
- Address cultural competence*
- Coordinate with the CDC Coordinated Council for Diversity in Public Health*

Priority #4: Examine opportunities to promote health equity through the Prevention in Public Health Fund

*Priority #5: Make recommendations regarding CHDIR
(Since this priority was articulated, a new iteration of CHDIR has been released).*

Discussion Points

Regarding the second priority, Dr. Ross recalled a recent conversation he had with Dr. Nadine Gracia, the Assistant Secretary for Minority Health and Director of HHS OMH. She expressed excitement about the prospect of collaboration and communication among subcommittees across agencies. A small group within HDS was tasked with creating a roster of agencies and

contact information for prospective subcommittees. Before HDS engages other agencies, however, it will be important to convey its and CDC's priorities concisely. He suggested that HDS have an internal conversation, perhaps at another meeting about the major issues to be shared with other agencies and the format for those discussions.

Dr. Sonya Hutchins commented that the Advisory Committee on Immunization Practices (ACIP) has been considering similar approaches. ACIP was founded in 1960 with the goal of reaching all children with vaccinations. The committee has a long history of health equity. HDS's links with other CDC advisory committees will depend on their need and mission.

Ms. Thompson wondered why, if they were intentional about driving a health equity agenda, they were still using the health disparities frame when there are major differences between the two. She serves as co-chair of the IOM Round Table on the Promotion of Health Equity and the Elimination of Health Disparities. The title of the Round Table reflects the members' desire to refer to health disparities, but to "lead with health equity." She was not suggesting renaming HDS; however, the term "health disparities" is rarely used in policy-related work. Health equity values and principles are imbedded in their conversations on the subcommittee, and she wondered about the reasons for keeping health disparities as their frame.

Dr. Liburd answered that in their view, health disparities are the public health problems that they seek to reduce and health equity is the goal. Health equity includes ensuring access to the resources that people need to be well. SDOHs, including access to high-quality healthcare, are the pathway for arriving at health equity.

Dr. Lichtveld noted that sometimes, it can be helpful to have a friend outside to get more recognition inside. Strategically, it will be useful to find a group to elevate the data, add "meat" to ongoing efforts, and bring higher visibility. The "currency inside" may then become greater. If members of HDS can be ambassadors for OMHHE and its work, they need to have one common message. The tool of consistent communication and priorities will be helpful.

Mr. Fukuzawa commented that HDS has been focused on CDC and on the broader public health community, but its most important audience is the director of CDC, as it operates as a subcommittee of the ACD. HDS must concentrate on what it wants the director to hear about an issue. Further, they should understand what ACD is working on so that HDS can have a voice in that work. Recent events in the country have led to more widespread conversations about race, which has become more visible and elevated. The events have exposed injustices with which health issues are associated. He hoped that HDS and the CDC director would remember the public health dimensions to the broader issues of race and injustice.

Ms. Wilson said that when she makes presentations, she shares slides with definitions to ensure that everyone "is on the same page." She defines the differences between health disparities, healthcare disparities, and health equity. She agreed with Dr. Liburd's characterization of health equity as a journey that requires collaboration with all sectors outside healthcare, such as education, transportation, nutrition, and others. With health equity as the goal, the disparities are the differences and gaps that must be reduced.

Dr. Liburd said that PolicyLink, Ms. Thompson's organization, has a broader agenda that focuses on a number of health equity indicators such as income and employment. CDC's aspiration toward health equity is to reduce health disparities and to eliminate the disparities that can be eliminated.

Dr. Ro raised the work of CHNAs. Given recent events of race and violence, she was glad to see an article on violence in the upcoming special supplement. She recalled when HDS was visited by the director of the National Center for Injury Prevention and Control (NCIPC) and the opportunities for additional work to be done to incorporate an equity lens into their work. Recent events are an unfortunate opportunity to drive SDOH work and to highlight equity issues. CHNAs should respond to what the community is calling out for. CDC needs to do the same thing. HDS can bring that issue, and issues of violence and inequities, to the CDC director for greater attention and focus.

Dr. Liburd noted that the director of the Division of Violence Prevention (DVP) within NCIPC would be a speaker at the next State of Health Equity Forum.

Dr. Richardson asked for suggestions regarding how to proceed in identifying HDS priorities. The next step would be to assign HDS members to commit time to bringing the ideas to fruition. She recognized a desire to follow up on the second priority from their previous list, which can include work to frame the message and determine to whom the message should be directed. This strategy is appropriate and potentially high-impact. They could address it as a group or divide into smaller groups with timetables for addressing specific aspects of it.

Mr. Fukuzawa commented that there is an agenda forming. There is heightened interest regarding SDOH, and HDS could be helpful in fostering conversations about SDOH and its emerging issues within CDC. Regarding health equity and health disparities, certain disparities are “uncomfortable” in the public discourse, such as violence and issues regarding boys and men of color. HDS might consider elevating these issues.

Dr. Ro said that the first priority on the list is well underway and there does not appear to be further need to pursue it. The third priority is a continuing issue, whether HDS works on it or whether it is pursued by other committees such as the Coordinating Council.

Dr. Ross clarified that the Coordinating Council is staffed by CDC. It has a mission, vision, and short- and long-term goals, but no formal charge since it operates as a task force. Its goals are consistent with much of what HDS has discussed.

Dr. Ro said that the fourth priority is a political issue that all HDS members are likely working on.

Dr. Richardson said that the rationale and driving forces behind the fourth priority are likely to reemerge as the health equity indicators work progresses. As with the workforce issue, HDS may remain involved by monitoring progress and action on the recommendations.

Dr. Ro noted that their work on opportunities cuts across all of the subcommittee’s efforts.

Dr. Richardson agreed and noted that the opportunity work also relates to the question of how much of CDC’s budget is devoted to health equity, whether through the Prevention in Public Health Fund (PPHF) or another mechanism. Thus far, that question could not be answered. Health equity should be imbedded into the apparatus by which CDC programs are currently rolled out, funded, and tracked in order to gather data. This issue is long-term, and work is ongoing, but it will take some time.

Ms. Thompson expressed concern regarding the PPHF. If the fund is eliminated, there should be a strategy to imbed health equity.

Dr. Ro agreed. HDS makes recommendations through the ACD and can continue to do so, speaking in favor of the PPHF because its investment is in prevention rather than treatment. Dr. Richardson said that PPHF is imbedded in the statutes of the ACA. Dr. Ro indicated that PPHF is targeted to be cut.

Ms. Thompson said that there is concern in the field because in the past, such as with the CTGs, programs begin, get traction, and then funding changes. One of her priorities is to make the case for the value of the continuation of PPHF.

Dr. Richardson said that efforts to articulate these ideas are best if they are not aimed at the ACD or CDC, but at Congress since decisions are made at the Congressional level rather than the agency level. Much happens at the agency level, however, that HDS can address. Recommendations that come from HDS to ACD and the CDC director are a strong mechanism. The recommendations should be constructed to include desired results, not just statements of principles and values. There are many possibilities and opportunities for HDS, and they must capitalize on the momentum of the meeting to commit to getting the work done.

Dr. Ro confirmed that the fifth recommendation could be removed from the list. With that removal, their priorities would be coordination of HDS across various organizations and addressing SDOH.

Dr. Richardson added that they could focus on violence as a public health issue.

Dr. Ro said that they could focus on how to raise emerging issues, or issues that have not yet had sufficient attention in the health equity agenda.

Dr. Lichtveld returned to Dr. Liburd's explanation of how SDOH are the pathway for moving from eliminating health disparities to achieving health equity. A paper could focus on viewing health equity through the lens of public health, or "from health disparities to health equity." HDS could bundle data and specific cases in a journal article, perhaps in the "Health Matters" section of the *American Journal of Public Health (AJPH)*. Another possibility is to publish in *Health Affairs*, which cuts across policy. The article could be definitional and discuss actual cases of how health equity is materialized, whether via examples in violence, HIV, workforce, or another issue. HDS may not be able to influence PPHF, but CUPS is at a crossroads. There is commitment to continue the program. There may be opportunities to have conversations with private foundations, beginning with the CDC Foundation, to create a more sustainable resource for CUPS. Affecting change in disparities in workforce in research and practice begins with CUPS, if not earlier. The program is proactive rather than reactive and should be a priority.

Dr. Ro suggested that the issues of precision medicine and epigenetics could be a priority area for HDS, as equity should be included in conversations as the issues develop. A subgroup of HDS could consider applying an equity lens as the fields progress.

Dr. Lichtveld said that current conversations about precision medicine focus on bench science.

Dr. Richardson pointed out that the current conversation does not understand the beginning concepts of community engagement. She is a co-investigator on a National Human Genome Research Institute (NHGRI) funded project regarding Apolipoprotein L1 (APO L1) and how to present information to African Americans who are at higher risk. She shared the concern and curiosity, but was not sure what HDS's role could be in the issue.

Dr. Ro commented on the structure of OMHHE, which has incorporated OWH. She wondered about men's health, specifically the health of men and young men of color.

Dr. Richardson said that the issue is clearly within OMHHE.

Dr. Ro noted that men's health is not specifically called out, and "form follows function." Disparities regarding men of color remain neglected.

Dr. Liburd said that OWH currently manages a site on the CDC website that focuses on men of color and men's health. There is an opportunity to grow it into something more meaningful and substantive, but the web page recognizes the importance of the health of men of color.

Dr. Ro asked whether it would be helpful for a group within HDS to create recommendations on what it would mean to expand the initiative further so that there is significant investment of resources and focus on that issue.

Dr. Richardson thanked HDS for the enthusiastic discussion, indicating that she and Dr. Liburd will build upon their deliberations to create a list of next steps and ask HDS members to volunteer to support them.

Presentation and Discussion with Jonathan Mermin, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Dr. Richardson indicated that a regular feature of the HDS meetings is a presentation and discussion with each of CDC's center director regarding the centers' work on health disparities and health equity. The invitation includes a set of questions for each center director to address. The sessions are an opportunity for HDS to understand the agency's work and to make the HDS members available as resources to the center directors.

Jonathan Mermin, MD, MPH, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) described health disparities in the diseases that are within the purview of his center. NCHHSTP focuses almost exclusively on "stigmatized diseases of inequity." The center sees some of the most profound disparities in the disease populations. Part of the center's explicit, overarching goal is to reduce health disparities and promote health equity. They have experienced successes and challenges related to measurement and goals.

There are tremendous racial and ethnic disparities related to HIV/AIDS, viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB). For instance, African Americans are 3 times more likely to have HIV infection than white Americans. As of a couple of years ago, African Americans had 12 times the reported rate of gonorrhea than white Americans; Asian Americans and Pacific Islanders comprised less than 5% of the total US population, but accounted for more than 50% of Americans living with chronic hepatitis C; and Asian Americans had the highest TB case rate in the US.

There are also significant issues associated with HIV and STDs among gay, bisexual, and other men who have sex with men (MSM). MSM account for 63% of new HIV infections and are the only group in which HIV infections are rising. The rate of HIV is over 40 times higher among gay men, and syphilis is 40 times more likely among gay and bisexual men. This group also accounts for 15% to 25% of all new hepatitis C infections. Similarly, Lesbian, Gay, Bisexual, and Transgender (LGBT) youth have increased health risk behaviors. These include increased incidences of injury, violence, attempted and complete suicide, tobacco, alcohol, and drugs (including injection drugs, which are over 8 times more common among LGBT youth than

among heterosexual youth). They also experience risks associated with diet and physical activity. If current trends continue, half of young black gay and bisexual men will have HIV by the age of 35, and half of all MSM will have HIV by the age of 50.

There are also differences in geography. Of all adults and adolescents with HIV, 46% live in the states of California, Texas, Florida, and New York. TB case rates of above 3 per 100,000 are reported by 9 states and Washington, DC. These areas account for 57% of the national TB total. Age is also a difference, particularly for STDs and hepatitis. Youth aged 15 through 24 comprise 27% of the sexually active population, but 50% of the 20 million annual new sexually transmitted infections (STIs) in the US. One in four new HIV infections occurs in youth aged 13 through 24 years. Approximately 12,000 youth in 2010 were infected with HIV. More than 75% of adults with hepatitis C are “Baby Boomers.”

NCHHSTP sees drastic socioeconomic differences as well. Every three years, the center conducts a study among heterosexuals in high-poverty, urban US areas with high prevalences of HIV. Approximately 2% of heterosexuals living in those areas have HIV infection, and in that context, there is no difference in HIV prevalence by race and ethnicity. The inner-city HIV prevalence is associated with homelessness, unemployment, and lower educational attainment. As annual household income decreases, the risk for HIV increases.

The center works to reduce these disparities and to promote equity. Reducing health disparities has been a priority for the center since it was created in 1995. The three key goals in the center’s current strategic plan include incidence reduction, morbidity and mortality reduction, and disparities reduction.

All of the center’s divisions are committed to incorporating equity into their strategies and their activities. Reducing disparities is also a key goal of the National HIV/AIDS Strategy and the HHS Viral Hepatitis Action Plan.

NCHHSTP adopts a tiered approach to STD, HIV, TB, and viral hepatitis prevention in the US, which includes the following components:

- ❑ Provide basic, fundamental knowledge for all Americans: the Division of Adolescent and School Health (DASH) works with educational institutions and the center also utilizes campaigns and other mechanisms to share information. The information includes how individuals can protect themselves, what puts them at risk, the importance of routine screenings so that people get the services they need, and campaigns.
- ❑ Community-level and structural approaches reach the hardest-hit geographic areas and populations. These mechanisms include widespread condom availability as well as targeting HIV, hepatitis, and TB testing to people at highest risk. The center uses community viral load as a conceptual framework for ensuring that as many people with HIV as possible have as little virus in their bodies as possible. There is a direct correlation between virus in the blood and transmission. This approach makes the environment safer and keeps people alive longer.
- ❑ The center engages in social marketing for behavior change and to foster support of community norms among populations at highest risk.
- ❑ Intense individual interventions for each of the center’s infections of interest are targeted to very high-risk individuals. These interventions range from clinical and behavioral to biomedical.

NCHHSTP utilizes an approach called “high-impact prevention.” This approach considers all of the different possible interventions and determines how to choose the ones that will be the most impactful. The approach applies to maximizing incidence reduction, morbidity and mortality reduction, and the effect on increasing equity and/or reducing disparities. Some interventions have more impact than others, and it is important to select the interventions that have the greatest impact. The approach includes:

- Gathering interventions
- Assessing the interventions’ efficacy and effectiveness, ideally in randomized controlled trials (RCTs) or a structured intervention
- Establishing the interventions’ cost and cost-effectiveness per infection averted or life-years saved
- Determining the feasibility of full-scale implementation to the populations in need
- Developing epidemic models to project the impact of the interventions
- Prioritizing the interventions
- Implementing and evaluating the programs

NCHHSTP’s strategic plan includes indicators for the specific goal of decreasing health disparities. The indicators range from reducing the rate of new diagnoses among certain racial and ethnic populations to reducing new infections among high-risk populations, such as HIV in injection drug users or MSM. A TB indicator is reducing cases in foreign-born persons, who are 13 times more likely to have TB than US-born persons. The indicators should be standard.

The center imbeds this approach into almost all of its work. For instance, the largest mechanism that the Division of HIV/AIDS Prevention (DHAP) has to provide resources is the HIV Prevention funding announcement, which provides approximately \$360 million annually to 68 health departments in every state, Washington, DC, six territories, and cities. The funds are allocated based on HIV prevalence. Previously, the funds were not well-matched to prevalence. It was politically difficult to implement the prevalence formula, but now there is support from the necessary partners for the approach. The approach allows for flexibility and response based on local epidemic modeling and needs. It requires health departments to focus on interventions that have the greatest impacts. The focus areas are relatively narrow.

The return on investment (ROI) of the center’s work is quite high at times. Some interventions should benefit everyone, while others should target specific populations. NCHHSTP has benefited from thinking specifically about where the interventions, activities, and programs should work, and then getting it done. The choice of jurisdictions or populations makes the interventions effective in reducing disparities.

The Expanded Testing Initiative (ETI), which is a component of the HIV funding announcement, provided approximately \$100 million over three years to 25 jurisdictions that were chosen because they had a certain number of AIDS diagnoses among African Americans. The program has since expanded to Latinos and gay men. The jurisdictions were chosen because they had disparities. The program encouraged two kinds of testing: routine screening in clinical settings and targeted testing for people at high risk who are often more difficult to access through the general healthcare system. In the program, 2.8 million people were tested. Of the 18,000 people newly diagnosed with HIV, 70% were African American and 12% were Latino. The program averted an estimated 3300 HIV infections and saved \$1 billion in direct medical costs, even incorporating the cost of antiretroviral therapy (ART), and saved two dollars for every dollar spent. The program is an illustration of doing good, saving lives, and saving money.

Other data show that the proportion of African Americans with HIV who know their status has increased disproportionately to white Americans, with the previous disparity no longer present.

A new funding announcement provides up to approximately \$185 million over three years for health departments to increase pre-exposure prophylaxis (PrEP) for MSM and transgender persons. New guidelines indicate that PrEP is highly effective in preventing acquisition of HIV infection. Another funding announcement focuses on using surveillance data to increase engagement and care. NCHHSTP has approximately \$60 million from the Minority AIDS Initiative from HHS to initiate collaborative service networks for MSM of color, providing LGBT-friendly and focused services in health centers. The center awarded over \$200 million over five years to 90 community-based organizations (CBOs) to deliver effective HIV prevention strategies focused on people of color, MSM, transgender persons, and people who inject drugs. The eligibility criteria in these funding announcements require these foci.

The Act Against AIDS Leadership Initiative is a partnership between CDC and 19 leading national organizations representing the populations hardest hit by HIV. It has 400 chapters of these organizations participating across the country. The program provides a small amount of seed money, generally for one person in an organization. Some of the results have been remarkable, as the program incorporates a broad swath of organizations that may not traditionally focus on HIV, but have taken it on because they want to increase their capacity and work with CDC.

One of the center's education campaigns focuses on hepatitis B. One out of 12 Asian Americans and Pacific Islanders has hepatitis B infection, and two-thirds of them do not know it. Approximately 20% of people with hepatitis B revive their infection, unless they are treated. Treatment is lifelong, but effective. NCHHSTP launched a national, multilingual campaign focused on Asian Americans and Pacific Islanders to increase testing and linkage to effective care. Other hepatitis prevention efforts include funding organizations to expand testing for hepatitis B and C, in many circumstances to incorporate the testing into routine clinical testing. Routine hepatitis C testing is recommended, based on age. Hepatitis B testing is recommended based on certain risk categories. When this testing has been adopted, people are diagnosed matched to the epidemic, with the same disparities.

There are major inequities associated with TB, with 66% of TB in the US among foreign-born persons. There have been successes in decreasing TB over the last 15 years in the US, but in many countries, a quarter of people contract TB, and it remains dormant in their lungs. There is a risk of TB emerging in their lifetime, and the risk is elevated for persons with HIV or who are otherwise immunocompromised. One of the ways to address the problem of latent TB infection (LTBI) becoming active is to screen people and then to treat them. The new policy for treating LTBI is once-a-week isoniazid treatment for twelve weeks, as opposed to nine months of daily therapy. Adherence and completion rates are greater for the new treatment protocol, and toxicity is less. Treatment of active TB still requires daily treatment. Many doctors have not seen TB in many years, so ensuring that people are screened requires patient and clinician education. NCHHSTP generated education materials in Spanish, Tagalog, and other languages. The homeless population is at high risk for TB. NCHHSTP has a national genotyping surveillance system that allows for quick response to outbreaks, particularly in homeless shelters. There is an ongoing outbreak of drug-resistant TB in Atlanta. It has spread to 8 states, and 90% of the cases are in African Americans and 50% have HIV. This outbreak is an example of tremendous disparity, and it has been difficult to address because of challenges for state and local health departments to address it.

CAPUS is an HIV program that has \$45 million total funding over three years. Eligibility for funding is limited to the 18 states with the highest HIV burden among African Americans and Latinos and with high AIDS diagnosis rates. AIDS can be avoided if HIV is diagnosed and treated quickly. CAPUS focuses on helping racial and ethnic minorities in the award states with HIV get virally suppressed, live a long, healthy life, and overcome the social determinants and economic obstacles that prevent the optimized linkage, retention, and engagement in care. Achieving these outcomes requires assisting with structural changes. The award states are working in creative ways, such as health department personnel acting as case managers to help patients get access to insurance, assistance with transportation, and a range of activities that are leading to success.

DASH addresses disparities through school health by aiming funding at states with the highest HIV burden and at school districts based on their burden, poverty level, and number of students. DASH also has a focus for some pilot programs on young MSM. School districts are encouraged to provide safe and supportive environments for LGBT youth. Health risks are monitored via the Youth Risk Behavior Survey (YRBS).

STD-related funding announcements also address disparities. An FOA offers greater flexibility to programs to direct resources to areas based on local need. The programs focus on adolescents and young adults, MSM, multi-drug resistant gonorrhea, and congenital syphilis. A new funding formula is based on population and disease burden. STD Prevention also has an HIV/STI curriculum for Historically Black Colleges and Universities (HBCUs) medical schools. The online curriculum has 14 modules on a range of topics and provides training for future doctors, nurses, and other healthcare providers.

NCHHSTP issued a SDOH White Paper in 2010. Commitments within that paper include:

- Disseminating guidance on SDOH ranging from definitions and indicators to data support;
- Creating a strategic communication plan to support actions by partners and program staff;
- Addressing SDOH and health equity in all FOAs, which include general language about SDOH as well as specific activities;
- Including structural, social, and other determinants in the existing prevention program portfolio;
- Developing materials and providing examples of SDOH activities for ongoing training with partners and staff; and
- Strengthening, diversifying, and augmenting the number of partners who engage in SDOH policy development.

The center has engaged in several consultations and activities that support the CDC workforce. These activities include a consultation on addressing SDOH, a health equity symposium, an Office of Health Equity Anniversary Symposium, and a new Public Health Leadership Fellowship Program that has been established to train students and recent graduates with interest in reducing disparities in the center's diseases of interest. NCHHSTP identifies and addresses key SDOH for programs. There are communication products and model data analyses to determine the impact of SDOH on disease rates. The center has also published three supplements and public health reports on SDOH.

Goals and measurements are difficult for a number of reasons. One way to measure disparity is to look at disease rates by race and ethnicity per 100,000. Another way is to compare rate ratios for certain races and ethnicities to rates for the entire population, other populations, or to the median. The sense of inequity is exemplified when these comparisons are made, but there are issues associated with what trends mean. The center developed a Racial/Ethnic Index of Disparity to determine where disparities are worst by disease. The method looks at the average percent difference between each subgroup. The disparities are worse for TB. The center created a target for decreasing disparities for each disease.

Reducing incidence or mortality for everyone often results in benefits for people who are disproportionately affected, but programs sometimes do not align. Sometimes, measuring impact by measuring years of life saved would either increase disparities or not meet needs, and a special program is needed to focus on maximizing effect on populations that are disproportionately affected. Targets are needed to demonstrate that the programs are reaching the goals. Since triple ART was first made available in 1995, there have been dramatic reductions in HIV-related mortality throughout the US. However, the disparity in mortality between blacks and whites in the US has increased as the relative mortality rate ratio increased.

There are substantial health disparities in HIV, viral hepatitis, STDs, and TB. Reducing disparities and promoting health equity is a top, explicit goal for NCHHSTP. Specific indicators, targets, and help are needed. Partnerships, workforce development, and champions are significant parts of this work. Workforce development sets the stage at the graduate and undergraduate levels for long-term mentorship and work. Maximizing reductions in disparities requires careful modeling, targeted distribution of resources, and thoughtful individual-, community-, and societal-level interventions.

Discussion Points

Dr. Richardson clarified that when center directors visit HDS, they are asked to provide an overview of the work of the center and major health equity work, reflecting to the extent possible the ways in which the programs monitor health disparities; the essential elements of health equity programs; the center's infrastructure to address health equity and its needs in that area; whether the center has a focus on health equity or disparities in its FOAs; the ways the center is advancing minority leadership and representation on the workforce of the center or the public health workforce in general; and if training programs are available.

Dr. Ross asked about acceptance of opt-in policy for hepatitis testing.

Dr. Mermin indicated that there is wide acceptance of opt-in policies for HIV, which have been encouraged by CDC for some time. The opt-in policy for hepatitis was never as controversial. There is widespread acceptance of the concept, but not widespread implementation of the concept. When CDC testing programs are direct, they are demonstrably effective. It is more challenging to assess indirect testing, such as when CDC works with health departments to establish screening systems through clinical decision tools in Epic in local hospitals. The concept has been shown in the US Department of Veterans Affairs (VA) system to triple the number of people diagnosed with HIV infection. It is not perfect, as there are ways of ignoring flags, but it can be effective with a strong champion in a hospital. The concept of routinizing screening has not reached full success. New treatment for hepatitis C is highly effective, with an over 90% cure rate. Attention in the media and from the drug companies has led to moves to increase screening, but entire jurisdictions have yet to be routinized.

In response to a question from Dr. Garza, Dr. Mermin said that all of Asia seems to have a severe hepatitis B issue. NCHHSTP frequently consults with the countries to address the issue. A World Health Organization (WHO) representative is stationed in these countries to provide guidance. There are questions associated with how to screen immigrants and refugees without stigma and how to help national programs improve.

Dr. Ross recalled his experience as Medical Director of a public hospital in St. Louis in the mid-1990s. His first response to the HIV crisis was to develop community workers to help interrupt the spread of the infection. The programs achieved success until they were defunded. He now chairs a health department in a large, inner city, and they are not seeing declines in STDs. He is trying to pursue a similar approach of securing interrupters. A similar approach is being applied to violence as a public health threat in other cities. There are some data regarding interrupters, and he wondered about additional data and practices from CDC on this strategy. Beyond SDOH, tangible, effective, sustainable, and community-based interventions are needed.

Dr. Mermin answered that there is hope and there are examples of places that have had success in HIV and STDs. There is scientific evidence available to support certain interventions, such as PrEP to prevent the acquisition of new HIV among high-risk groups and ART. These tools are powerful, but the development of new tools may have led to some complacency as HIV is not prioritized as a health problem in the US. At the same time, prevalence was increasing in gay men and not decreasing in heterosexuals. People were not engaging in sexual behavior modification as they had in the past. This situation became a vicious cycle in certain populations. There is an increasing concentration of syphilis and gonorrhea among gay and bisexual men, and prevalence of HIV is over 40 times higher among gay men than heterosexuals. Over the past 10 years, HIV rates have decreased among heterosexual men and women, including African Americans, and among intravenous drug users. The services have reached a level of coverage, the risk of transmission has decreased, and the epidemiological pressure is such that a "tipping point" has been reached. The greatest decreases among heterosexual men and women were among African American women. San Francisco has seen decreasing incidence rates due to PrEP and ART and also due to the application of a systematic approach of diagnosis, treatment, and support. Medicaid expansion and other activities have allowed people to get care. They also have very strong community-based programs. There are examples in other places of the mixture of community-based program that mobilize effectively and the systems that provide necessary services. Both pieces of the equation are necessary for success.

Dr. Lichtveld noted that the field of community health workers has advanced significantly. Successes have been observed in cancer, diabetes, and asthma by utilizing a four-tier approach: community health workers who have general health knowledge; workers with core public health competencies who can be conversant in disease-specific areas; workers with more in-depth disease-specific focus who can move from navigating to intervening; and health professionals who are imbedded in a clinical care team within the hospital setting. An emerging trend is imbedding the “tier three” community health worker interventionists in Federally Qualified Health Centers (FQHCs). The approach provides a “one-stop shop” care team. These workers are in the clinics and in the communities, bringing clients who need the services to the FQHCs.

Dr. Ross stressed that the model requires funding, and a lack of support leads to the vicious cycles.

Dr. Mermin commented on major budget cuts experienced by state and local health departments. When programs lose funding, they do not return. Public health can have a vision of the programs that will make the biggest difference in a problem, and when resources are available, the programs can be ready. There is room for greater efficiency in both program coordination and service integration. For instance, pilot programs that screen and diagnose people for hepatitis C should also screen for HIV. People with HIV are at high risk for STDs and should be screened. These efficiencies should be considered from the patient’s point of view so that people are educated regarding a comprehensive picture of health and a cohesive approach to health. Notable successes are achieved when there are champions who care about problems.

Dr. Lichtveld said that the work could be done in a targeted fashion, either in populations or in specific diseases. In her experience, funds have been applied to the interventionists from the supervisor’s salary. This approach involves supervisors and incorporates evaluation and monitoring at the program and individual levels.

Dr. Ro said that her area engages in some hepatitis B work, but the broader community hepatitis B campaign no longer exists due to a lack of funding. She wondered how to imbed a comprehensive approach so that it is not dependent upon public health campaigns that are dependent upon the availability of resources. She asked about lessons learned from other sectors regarding SDOH that will help the fields of public health and population health management more broadly.

Dr. Mermin answered that the campaigns tend to focus on people, as certain information must be shared with the public and with people at higher risk. To burden them with the responsibility of bringing themselves to clinic or another service, however, and of knowing what they want is too much. At the same time, leveraging a system like the FQHCs or a health district can accomplish much. The enabling environment of the community-based programs or of communications is needed in order to establish trust. The hepatitis B campaigns have been well-received and have led to increases in testing and improved public understanding. Regarding working with other sectors, housing has been a significant issue not only in TB, but also in HIV. NCHHSTP collaborated with HUD on a randomized controlled trial (RCT) regarding whether housing benefited people with HIV. Individuals were more likely to be virally suppressed if they were provided housing. The idea is that there is a social, physical, and economic environment that allows people to live healthier lives. Communications continue to be frequent with HUD and its HIV housing program. CDC can work with other agencies to provide information and have influence outside its direct purview. SDOH are imbedded in all of

NCHHSTP's surveillance reports. Surveillance data for HIV, TB, STDs, and other diseases are available on the Web by county and by race and ethnicity. There is room for evolution with the ACA and with changing times. Simple changes can make a difference; for instance, if Medicaid were expanded in the State of Georgia, it would make a significant difference in the treatment and infection rates of most of the center's diseases of interest.

Dr. Richardson agreed and noted that health indicators play out in this policy environment. She commented on the potentially key role that emergency departments can play in screening and surveillance. For many disparities populations and many of these conditions, the emergency department is the only place in the healthcare system to connect with high-risk populations, particularly young people. When potential impacts of screening in the emergency department first for HIV, and in some places for STDs, it became a recommendation and an unfunded mandate in emergency departments. She noted that FOAs may miss the role that emergency departments can play.

Mr. Vargas asked about data or experience related to the acceptance of PrEP within gay, male communities of color, and about barriers to access to PrEP that specifically affect gay men of color.

Dr. Mermin said that it has been several years since the PrEP guidelines were released. There has been a "sea change" this year, as data showing its effectiveness are available and "real-world" pilot programs have shown greater effectiveness even than the RCTs. Therefore, there is more demand. African American gay men live in an environment of such risk that it is particularly beneficial for them to access PrEP. Regarding obstacles, Medicaid, Medicare, and private insurers cover PrEP. However, it can be expensive if an individual has a large copay. Individuals in the "middle ground" that do not meet a drug company's Patient Assistance Program may experience a financial obstacle in meeting the copay. Further, a primary care physician may not be as comfortable or familiar with PrEP, where an HIV doctor may be more comfortable prescribing it. Bringing PrEP to the primary care setting, including FQHCs, is an ongoing area. Some jurisdictions are being funded to do this work, but more needs to be done in order for PrEP to take hold.

Ms. Thompson thanked Dr. Mermin for his talk, noting that her organization focuses on social justice and advancing social and economic justice issues through a health equity lens, and the health implications of that work is clear.

Dr. Mermin said that NCHHSTP exchanges ideas with other CDC centers regarding large policy leverage points. For instance, PrEP is a prevention intervention that has been proven to work in a randomized trial and multiple other studies. The US Food and Drug Administration (FDA) has approved it, but the US Preventive Services Task Force (USPSTF) has not reviewed it yet. He hoped that PrEP could be more available when USPSTF reviews and approves it, thereby making it more normalized in the community. He wondered about other policy-level initiatives where NCHHSTP or its partners could make a difference.

Dr. Richardson commented on the relative lack of familiarity of many healthcare providers about PrEP. This area has potential for partnership with professional organizations or for targeted efforts to present talks at national meetings. Even if individuals are aware of PrEP and ask for it, the response of a general internist at a health clinic is uncertain.

Dr. Liburd noted that many FQHCs prescribe and administer PrEP through their pharmacies.

Dr. Mermin said that the center has engaged with organizations that are LGBT-focused. A new FOA focuses on collaborations between CBOs and FQHCs to build an LGBT-friendly environment with standard services, which would include PrEP.

Dr. Liburd indicated that NACHC is a potential partner. She asked whether PrEP is only for gay men. Dr. Mermin clarified that PrEP is for anyone at substantial risk for HIV infection. Dr. Liburd said that in order for a person to be a candidate for PrEP, he or she has to disclose high-risk behaviors. In some communities, especially small ones, that disclosure could be a barrier. She asked about strategies to minimize that barrier.

Dr. Mermin said that STD clinics are frequently publicly-funded. Having an STD increases future risk of STDs and HIV. In the STD clinic, there is leverage to talk about potential risk behavior. The primary care physician may be more likely to have difficulty talking about sexual history. There are efforts to increase the use of sexual histories by doctors.

Dr. Richardson agreed and said that if a person is being treated for one STD, he or she should be screened for other STDs and HIV. It is one thing not to disclose risk behavior, but when a person is diagnosed with an STD, health professionals should understand the connections among all STIs and the importance of screening and treating for them. This message has not percolated out to the healthcare community and could be a good target area for a campaign.

Dr. Ross recalled a recent experience when he went to the health department's STD clinic as a "walk in your shoes" exercise. He found the visit to be extremely stigmatizing. As a result of that visit, one of his colleagues created "The Spot" to reduce the level of stigma. It is a nonprofit community-based place, not an FQHC, staffed by certified young individuals who serve as interrupters. They are based in the neighborhood area. "The Spot" is overwhelmed with people seeking services, as it circumvents a number of hurdles associated with care. The model clearly works, but scaling it up will be a challenge.

Dr. Lichtveld indicated that in her time working in environmental health, they developed continuing education credit using case studies in environmental medicine. She wondered about creating credits using case studies in STDs and presenting them at the National Primary Care Association annual meeting. The approach is a "low-hanging fruit" way to reach out and increase the knowledge of primary care practitioners in addition to FQHCs. The Patient-Centered Outcomes Research Institute (PCORI) has brought together evaluators, health systems experts, clinicians, and public health practitioners. It may represent an opportunity for NCHHSTP to partner, particularly regarding community health workers and interventionists. There may be opportunities associated with community health workers and the ACA as well.

Dr. Richardson thanked Dr. Mermin for his time and congratulated him for the center's good work and self-awareness, as well as self-criticism and analysis. She emphasized that HDS is happy to serve as a resource.

Public Comment Period

Dr. Richardson opened the floor for public comment at 4:44 p.m. Hearing none, she proceeded with the agenda.

Final Comments / Meeting Adjournment

Dr. Richardson indicated that she and Dr. Liburd would consult on organizing next steps for HDS. They would put out a call for volunteers for workgroups to move ahead on the subcommittee's ideas and priorities. The workgroups work via conference call between the HDS meetings.

Dr. Ro suggested that the workgroups would benefit from starting with a clear understanding of what their aims are, perhaps with a format so that they can be succinct as they move forward.

Dr. Richardson noted that in-person HDS meetings are typically scheduled adjacent to the State of Health Equity Forum at CDC in order to allow those subcommittee members who are able to attend the event. The participation of HDS elevates the event internally and supports health equity efforts at CDC.

Dr. Liburd announced that the annual Minority Health Month program is scheduled for April 22, 2016. The program focus will be Hispanic health. The planning committee includes two external partners as well as planners within CDC. The HDS meeting may piggyback with that program, or with the ACD meeting. The entire month of April is Minority Health Month.

Dr. Ross noted that there may be activities in Washington, DC, during the third week of April.

Dr. Richardson observed interest among HDS members regarding the ACD. She asked that information about the ACD, including previous meeting minutes, be shared with HDS. The ACD typically meets in person twice a year. They have met via teleconference due to reduced budgets, and there are teleconference meetings when specific actions need to be taken.

Dr. Richardson asked again for any public comment. Hearing none, the meeting adjourned at 4:51 p.m.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 14, 2015 meeting of the Health Disparities Subcommittee of the Advisory Committee to the Director, CDC are accurate and complete.

Date

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

Attachment #1: Meeting Attendance

HDS Members Present

David Fukuzawa, MDiv, MSA

Program Director-Health
The Kresge Foundation

Mary Garza, PhD, MPH

Assistant Professor
University of Maryland School of Public Health

Garth Graham, MD, MPH

President
Aetna Foundation
(via telephone)

Willi Horner-Johnson, PhD

Research Assistant Professor
Oregon Health and Science University Institute on Development and Disability
(via telephone)

Anthony B. Iton, MD, JD, MPH

Senior Vice President
Healthy Communities, The California Endowment
(via telephone)

Maureen Lichtveld, MD, MPH

Professor and Chair
Freeport McMorRan Chair of Environmental Policy
Tulane University School of Public Health and Tropical Medicine

Lynne D. Richardson, MD, FACEP (Chair)

Professor and Vice Chair of Emergency Medicine
Professor of Population Health Evidence and Policy
Icahn School of Medicine at Mount Sinai

Marguerite Ro, DrPH

Chief, APDE (Assessment, Policy Development, and Evaluation) Section, Public Health
Seattle-King County

Will Ross, MD, MPH

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

Bobbi Ryder

CEO
National Center for Farmworker Health
(via telephone)

Mildred Thompson, MSW

Senior Director and Director
PolicyLink Center for Health Equity

Hector Vargas, JD

Executive Director
Gay, Lesbian Medical Association (GLMA): Health Professionals Advancing LGBT Equality
(via telephone)

Cheri Wilson, MA, MS, CPHQ

Faculty Research Associate
Health Policy and Management Department
Program Director, Culture-Quality-Collaborative

HDS Members Absent

David R. Williams, PhD

Professor of Public Health
Professor of African and African American Studies and of Sociology
Harvard School of Public Health

CDC Staff Present

Gwen Baker

Program Specialist
Office of Minority Health and Health Equity

Hazel Dean, PhD

Deputy Director
National Center for HIV/AIDS, Viral Hepatitis, TB and STD Prevention

Julio Dicient-Taillepierre, MS

Public Health Analyst/Team Lead
Office of Minority Health and Health Equity

Wayne Duffus, MD, PhD

Associate Director for Health Equity
National Center for HIV/AIDS, Viral Hepatitis, TB and STD Prevention

Mary E. Hall, MPH

Associate Director for Policy
Office of Minority Health and Health Equity

Sonja Hutchens, MD, DrPH, MPH

Medical Epidemiologist
Office of Minority Health and Health Equity

Leandris Liburd, PhD, M.P.H., M.A (Designated Federal Officer)

Associate Director for Minority Health & Health Equity

Judy Lipshutz

Office of State, Tribal, Local and Territorial Support

Jonathan Mermin, MD, MPH

Director

National Center for HIV/AIDS, Viral Hepatitis, TB and STD Prevention

James Nelson, PhD

Chief, Diversity and Inclusion Program

Office of Minority Health and Health Equity

Ana Penman-Aguliar, PhD

Associate Director for Science

Office of Minority Health and Health Equity

General Public Present:

Kendra Cox, MA

Medical & Scientific Writer/Editor

Cambridge Communications & Training Institute

Attachment #2: Acronyms Used in this Document

Acronym	Expansion
ACA	(Patient Protection and) Affordable Care Act
ACD	Advisory Committee to the Director
ACIP	Advisory Committee on Immunization Practices
ADC	Associate Director for Communications
<i>AJPH</i>	<i>American Journal of Public Health</i>
APHA	American Public Health Association
APOL1	Apolipoprotein L1
ART	Antiretroviral Therapy
ASTHO	Association of State and Territorial Health Officials
BRFSS	Behavioral Risk Factor Surveillance System
CAPUS	Care and Prevention in the United States
CBO	Community-Based Organization
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CEHCD	Commission to End Health Care Disparities
CEPH	Council on Education for Public Health
CEU	Continuing Education Unit
<i>CHDIR</i>	<i>CDC Health Disparities and Inequalities Report</i>
CHNA	Community Health Needs Assessment
CIO	Centers, Institutes, and Offices
CMS	Centers for Medicare and Medicaid Services
CSELS	Center for Surveillance, Epidemiology and Laboratory Services
CSTE	Council of State and Territorial Epidemiologists
CTG	Community Transformation Grant
CUPS	CDC Undergraduate Public Health Scholars
DASH	Division of Adolescent and School Health
DC	District of Columbia
DCPC	Division of Cancer Prevention and Control
DFO	Designated Federal Official
DHAP	Division of HIV/AIDS Prevention
DM	Diversity and Inclusion Management (Program)
DOL	(United States) Department of Labor
DVP	Division of Violence Prevention
ED	(United States) Department of Education
EHR	Electronic Health Record
ETI	Expanded Testing Initiative
FDA	(United States) Food and Drug Administration
FOA	Funding Opportunity Announcement
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HBCU	Historically Black Colleges and University
HDS	Health Disparities Subcommittee
HHS	(United States Department of) Health and Human Services
HIV	Human Immunodeficiency Virus
HP	Healthy People (2020)

Acronym	Expansion
HSHPs	Hispanic-Serving Health Professions Schools
HUD	(United States) Department of Housing and Urban Development
IOM	Institute of Medicine
JAPER	Joint Action Plan to Eliminate Racial and Ethnic Discrimination and Promote Equality
<i>JPHMP</i>	<i>Journal of Public Health Management and Practice</i>
LGBT	Lesbian, Gay, Bisexual, and Transgender
LTBI	Latent Tuberculosis Infection
MHHE	Minority Health and Health Equity
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MOU	Memorandum of Understanding
MPH	Masters of Public Health
MSM	Men who have Sex with Men
NACCHO	National Association of County and City Health Officials
NACHC	National Association of Community Health Centers
NACHC	National Association of Community Health Centers
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NHGRI	National Human Genome Research Institute
NHIS	National Health Interview Survey
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NIMHD	National Institute on Minority Health and Health Disparities
OADP	Office of the Associate Director for Policy
OADS	Office of the Associate Director for Science
OD	Office of the Director
OGA	Office of Global Affairs
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMHHE	Office of Minority Health and Health Equity
OSTLTS	Office for State, Tribal, Local and Territorial Support
OWH	Office of Women's Health
PAHO	Pan American Health Organization
PCORI	Patient-Centered Outcomes Research Institute
PHAB	Public Health Accreditation Board
PHAP	Public Health Associates Program
PMAP	Performance Management Assessment Process
PMI	Precision Medicine Initiative
PPHF	Prevention and Public Health Fund
PrEP	Pre-Exposure Prophylaxis
PROMIS	Patient Reported Outcome Measurement System
RCT	Randomized Controlled Trial
RHEC	Regional Health Equity Council



Acronym	Expansion
ROI	Return on Investment
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SIM	State Innovation Model
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STLT	State, Tribal, Local, and Territorial (Subcommittee)
TB	Tuberculosis
US	United States
USPSTF	United States Preventive Services Task Force
VA	(United States Department of) Veterans Affairs
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

