Board of Scientific Counselors (BSC)
Center for Preparedness and Response (CPR) Meeting
Monday, January 23, 2023
Virtual

Contents

BOARD OF SCIENTIFIC COUNSELORS (BSC)
CENTER FOR PREPAREDNESS AND RESPONSE (CPR)
MEETING
MONDAY, JANUARY 23, 2023
VIRTUAL/IN-PERSON

Roll Call, Welcome

Kimberly Lochner, ScD; Deputy Associate Director for Science, CPR and Designated Federal Officer, BSC CPR

Dr. Lochner reviewed the BSC responsibilities, as per its charter, and conducted roll call. During roll call board members were asked to identify any conflicts of interest. No conflicts were identified. As quorum was met, Dr. Lochner turned the meeting over to the BSC Chair, Dr. Slemp, and the meeting was called to order at 1:09 PM EST.

Dr. Lochner monitored attendance throughout the meeting to ensure quorum was upheld. BSC Members attended via Zoom and were asked to keep their video on to assure attendance. The BSC Members were instructed not to conduct discussions through the Zoom chat feature. Public comments would occur during the public comment portion of the agenda only.

All participants agreed to have their comments recorded and speakers were instructed to identify themselves before speaking to ensure an accurate record was created.

Cathy Slemp, MD, MPH; Chair, BSC

Dr. Slemp reminded the board that the purpose of the webinar was to follow up on the November 2022 meeting and take a deeper dive into the topic of health equity, with the hopes of potentially standing up a health equity workgroup. Within the BSC, workgroups are a mechanism for finding practical solutions for some of CPR's complex issues utilizing the additional expertise of the BSC and other subject matter experts.

CPR Welcome

Henry Walke, MD, MPH; Director, CPR, CDC

Dr. Walke highlighted a few of CPR's activities. The Ebola outbreak in Uganda ended. CDC assisted with containment efforts of the virus, as well as travel logistics for Ugandan tourists. On the domestic side, CDC also worked closely with its federal partners and the states on hospital readiness. There will be an after-action report created on the response efforts.

Over the winter holidays, CDC implemented predeparture COVID testing for travelers originating from China, Hong Kong, and Macao. The number of airports covered by traveler-based genomic surveillance program was also increased to seven airports. This effort was in

response to the increase in community transmission of COVID currently in China. The goal is to hinder the emergence of a new variant.

CPR honored Dr. Martin Luther King, Jr. Day, with an invitation for staff to reflect on the principles of racial equality and nonviolent social change. Staff were encouraged to explore emergency response volunteering opportunities in their communities with a focus on the most vulnerable populations, in addition to continuing to support CPR's Diversity Equity, Inclusion, and Accessibility and Belonging (DEIA) initiatives.

Last year, Dr. Walensky launched the CDC Moving Forward Initiative. The key objectives are to share scientific findings and data faster; translate science into practical, easy-to-understand policy; prioritize public health communications; promote result-based partnerships; and develop a workforce that is prepared for future emergencies. More information will be made public regarding reorganization and key activities in the near future.

CPR Health Equity Discussion

Cathy Slemp, MD, MPH; Chair, BSC CPR

During the November 2022 BSC CPR meeting, a robust discussion occurred regarding health equity and the initiatives across CDC directed towards DEIA. It was determined that there was an opportunity for the BSC to support CPR in operationalizing this concept and helping to shape the structures, partnerships, and broader systems needed to have a significant impact. Ms. Romanoff presented some of the activities currently ongoing within CPR to be considered as part of the discussion.

Lovisa Romanoff, MS, MPH; Deputy Director, Management & Operations, CPR

In February of 2021, Dr. Walensky directed the creation of CDC's first-ever health equity science and intervention Strategy, known as CORE. The acronym means the following:

- C: Cultivate comprehensive health equity science
- O: Optimize interventions
- R: Reinforce and expand robust partnerships
- E: Enhance capacity and workforce diversity and inclusion

COVID-19 demonstrated that health disparities are long-standing and pervasive. They disproportionately impact people of color, those with disabilities, individuals residing in rural areas, and individuals in the LGBTQ community. To meet the Agency's mission, a strategic-coordinated approach was needed across all levels of the agency to locate the area where the most impact, in terms of health equity, could be garnered and disseminated all the way to the community level. CORE is a collaborative effort led by the Office of Science, Office of Minority Health and Health Equity, and the Office of the Associate Director for Policy and Strategy. It challenges CDC to integrate health equity into all its work. Every division and center across CDC has been tasked with developing health equity goals and milestones.

CDC has been charged with developing science agendas that will advance health equity science while building the evidence base; creating intervention plans with targeted goals, approaches, and metrics; and identifying multisector partnerships, internal systems, and resources to ensure successful implementation of its science agendas. They are also tasked with evaluating for efficacy.

CPR has the unique role of ensuring that health equity principles and best practices are at the core of all preparedness efforts for pandemics and emergency responses. The health equity vision for preparedness is to maximize the program's ability to promote health equity in all-hazards preparedness, as a prepared community is a resilient one free of health inequity. The health equity vision for responses is to incorporate lessons learned from past and present CDC responses, including the COVID-19 pandemic and integrate health equity principles and best practices into all future response activities.

The high-level 2023-2024 health equity goal is to align CPR's priorities to CDC's CORE pillars with the bulk of the activities centered on programmatic interventions. The first activity is to ensure that the internal workforce reflects the nation. Communication and partnership strategies will be utilized to increase diversity, equity, inclusion, and belonging across CPR. Internal resources have been allocated to address those efforts. Work began by hosting focusing groups and developing fact sheets on the demographics of the workforce, as well as examining the job series. This helped to paint a picture of the organization and spotlight areas for improvement. As a result of the analysis, nine strategies were generated that will increase DEIA across CPR's workforce, and a comprehensive action plan was created.

CPR also added health equity considerations and projects that can be accessed for both internal and external funding. This will expand the evidence base for health equity activities and strengthen the Agency's scientific preparedness and response efforts for populations that are disproportionately impacted during health emergencies.

There are various programmatic interventions, whose goals are listed below:

- *Promoting Health Equity to Advance State and Local Readiness:* Advance health equity for populations at risk of disproportional impact during a public health emergency by including additional health equity considerations in the PHEP guidance.
- *Incorporating Health Equity in CDC's Emergency Management Program:* Build health equity roles into the CDC All-hazards plan and expand existing Agency-wide response workforce training to include a health equity focus.
- *Promoting Health Equity to Strengthen Regional Preparedness and Response Capacity:* Develop and deliver a master's-level epidemiology training initiative to select members of the current public health workforce in all participating U.S.-affiliated Pacific Island jurisdictions.
- *Promoting Health Equity through Strategic Planning:* Investigate and pursue key strategies that build upon CPR's existing and future preparedness and response efforts

to address the social determinants of health (SDOH) and promote health equity and community resilience across the Nation.

The proposed Health Equity Workgroup will provide input to the BSC CPR on activities and/or strategies related to the scope and implementation of CPR's CORE strategy, center-led health equity activities and strategies, and strategic planning related to coordination with stakeholders outside of CPR. The Workgroup's anticipated initial activities will include the following:

- Provide input on current CPR health equity strategies and activities
- Provide insight on health equity success stories related to preparedness and response
- Identify areas of overlap or collaboration with stakeholders

To start the discussion, Ms. Romanoff posed two questions to the BSC.

1. Are there other areas within preparedness and response that would benefit from additional health equity initiatives? Where are the gaps?
2. In what ways could a BSC workgroup be helpful related to health equity?

Before discussing the possibility of standing up a workgroup, Dr. Slemp asked the BSC whether a workgroup should be created and if the board could add meaningful input. She opened the floor to discuss if there was consensus to the idea. If there is consensus, then terms of reference would need to be created. The terms of reference outline the purpose, scope, activities, and membership. A vote to stand up the workgroup will come in the near future once the terms of reference are determined. Below is a summary of some of the discussion points that arose.

Comments from the BSC:

- Extremely important work and deserves a workgroup, but the challenge will be determining ways to measure effectiveness. It is easier to measure equality but equity is much more difficult. We need to measure our efforts and the outcomes.
- Health equity is a wicked problem. Therefore, we must be clear on scale or level at which we are going to work. Where can we have impact? Solving this problem requires so many other components and a more systematic and systemic thinking and approach.
- Is health equity not something that each and every one of us should be engaged in? And if it is so fundamental and important, why is it being siloed into one working group? It should be a part of each activity that we engage in. One group cannot solve it all. If we do create a working group, the critical components that need to be included for it to be successful include having a much defined, specific, crystalized set of activities and goals; sun-setting date or timeframe; and a report of progress.
- Maybe the first step is to identify the high leverage areas.
- It is important to first define the scope and then secondly determine the indicators so that we know that we are advancing in our efforts. Also, I feel that the diversity of the BSC makes a difference because we can speak from our distinct perspective. For

example, my perspectives will be that of a Latina. Therefore, the diversity of our group in itself provides diverse viewpoints and ideas.

- What is missing is the voice of the very people we are talking about. You can only get that voice through connections that are respectful. This should start with a reflection on what is CDC doing now that needs to change to be able to come from a place of respect with these various communities.
- We should also think of who else we need to partner with in order to be successful.
- We need individuals who work in the area of social vulnerability assessment to provide an understanding of what tools are already available and are being used to examine social vulnerability at the local and county level. How can these kinds of tools be used in CDC programs and practices?
- We need representation from community members who live in a majority-minority community.
- Another perspective is rural versus urban. With COVID, for example, rural America had the highest rates of COVID for a variety of reasons and was disproportionately impacted.
- Perform a scan of other government agencies that have or are working on this issue and garnering some of their lessons learned. This may help us find a starting point and some possible outcomes.
- Oftentimes the data that has been collected thus far does not include any metrics on equality and is not inclusive of the very groups we are trying to reach.
- These communities are not helpless. There is a tremendous amount of creativity, innovativeness, dynamism, and knowledge within these communities, and it is insulting to them when we ignore their resourcefulness and the assets they have created. Our workgroup should identify, highlight, amplify, and find ways to tap into those assets already created within the community.
- Examine the key elements of a response and make recommendations around areas such as medical counter measure distribution or clinical guidance.
- There will be people with counter priorities that are trying to work against what we are trying to do. So, how do we engage the vulnerable populations so that we address their concerns about what we are proposing and ensure that our work is seen as trustworthy? There are DEIA efforts happening across many companies and organizations.
- Early in the COVID pandemic, there were populations that were disproportionately impacted such as long-term care facilities, those in homeless shelters, and among incarcerated individuals. These populations often are overrepresented by certain racial and ethnic groups. These may be areas where progress can be made quicker in addressing inequities experienced in these environments.
- In the laboratories, it was difficult to get access to specimens during the response to do assay development and examine the progress of the disease. If we could focus on mechanisms to get appropriate specimens from affected segments of the population, it would be helpful and aid in research. It will also help us to learn our effectiveness in a response.

- Maybe one concrete place to start is to challenge our own assumptions and the biases that led into the response plans that have already been developed. In the early days of preparedness and response, the plans were ridiculously bias and made for basically healthy people in the community. We can take any of the past responses and try to highlight the assumptions that were made in the response planning. This can help us to understand the mindset at that time. This should be an exercise that we do going forward, where we challenge our biases and assumptions on an ongoing basis.
- This is really an examination of healthcare delivery and the overlap of many different operations, such as testing, communication, outreach, engagement, and medical countermeasure delivery. This will look different depending on the jurisdiction, and that is part of the challenge. Therefore, building the connections with community-based organizations before a response is crucial.
- It is important to engage the medical sector, the Council of State and Territorial Epidemiologists (CSTE), and the National Association of County and City Health Officials (NACCHO). CSTE and NACCHO have direct impact on public health jurisdictions' planning and preparedness efforts. There will also need to be capacity that is flexible enough to bridge multiple types of systems into the response.
- This discussion reminds me of the importance of an all-sector response. When religious leaders, community organizers and other established business groups are incorporated into response efforts, you see the most impact because among these groups relationships exists and there is trust from the community. Healthy People 2030 utilized an all-sector response and incorporated several sectors such as businesses, regulatory, banking, finance, neighborhood, religious organizations, and so forth. In this type of response, a lot can be accomplished with a small amount of money, and there can be engagement of leaders ahead of time. Imagine having a strong network of individuals in various sectors that can be called on and activated in the next response. We should think of how we can play that out in terms of preparedness.
- Another thing to incorporate is language. Early in COVID, there was an issue with finding translators. In our area, we incorporated a Hispanic minister and found twenty-five translators instantly thereby eliminating the time it would have taken to contract and buy these services from a translation service. Once you find these types of community-level aids, we need to find a way to sustain them for future responses.
- When examining past response efforts, we should look for areas where our language may have contributed to already existing stigmas. We should gain an understanding of how stigma impacts people's willingness to access public health and healthcare and use those lessons learned going forward.
- It might be a good idea to broaden our thinking to not only pandemics and outbreaks but also other kinds of public health emergencies that have critical implications for underrepresented groups, for example heat waves, contamination after hurricanes and floods, and the likes. These are events where CDC will be involved and will need to appreciate the health inequities that accompany these kinds of emergencies.

Dr. Slemp quickly summarized some of the overarching themes she heard during the discussion to contrast with the purpose and scope of the potential working group. Below is her summary.

- Tools that can be used in this arena and a scan of what is already in place that can be built upon
- Importance of measurement to gauge progress
- Role of relationships and partnerships and building trust in advance of disasters
- Identifying and amplifying assets that communities bring and be informed by them and follow that leadership
- Activities around all-sector work and building the capacity of communities for doing work across sectors in advance of disasters
- Activities around challenging assumptions and biases that were brought to the table early on and examining those identified
- Checking language for stigma and how it impacts working across communities and how it can block access and ways to remedy those issues
- How to rapidly gain community input to CPR in a response in a practical manner
- Think about future disasters and what can be anticipated

In terms of expertise to include in the workgroup, Dr. Slemp summarized the following list of groups or sectors to include.

- State and community level
- Urban and rural
- Government and nongovernmental sectors
- Venue specific that are impacted such as incarcerated populations, homeless, long-term care facilities, childcare
- Healthcare and public health
- Demographic and geographic representation

Ms. Romanoff reminded the BSC that the working group would not need to address all of the points but would rather provide creative thinking on how to address equity. Dr. Slemp agreed and suggested that CPR determine from the list which ideas are high-leverage, apply to the visions, short-term, and long-term. Ms. Romanoff after listening to the discussion felt metrics to gauge success should be included in the workgroup's purpose. Dr. Walke added including ways to engage communities that are affected and gain their input would be helpful, as well as determining ways to plan for that type of engagement before an event and sustain that type of input going forward would be beneficial. Dr. Slemp felt this may be a longer-standing workgroup that reports back to CPR on a couple of topics at a time with specific recommendations.

She asked Dr. Walke how long should the workgroup convene because she felt there may need to be some flexibility due to the list of areas recommended and the possibility of other issues that may be uncovered. Dr. Walke felt a year would be reasonable. CPR will think through the

scope and try to narrow the list of responsibilities to fit that timeframe. The most important step, he felt, was engaging in this conversation to get the BSC's perspective that will help guide CPR's thinking and planning for the workgroup. In the next BSC meeting, a proposed terms of reference will be presented that can be further discussed.

Before moving to public comments, Dr. Horney added the long-term solution is a workforce that looks like the people who are having the inequities in the response. Huge efforts such as loan-forgiveness are something that minority students talk about a lot and those types of pieces can have a huge impact on what the future workforce will look like.

Public Comment Period

Members of the public were given the opportunity to speak at the meeting. During the public comment period, Mr. John Muller, a retired licensed civil and control system engineer, with an engineering degree in geophysics from the Colorado School of Mines, provided oral public comments via Zoom regarding his concern for the vulnerabilities of the public's drinking water supplies due to artificial water fluoridation and asked the Board to promote environmental justice specifically with respect to Executive Order 14008 and 13990.

Meeting Recap and Adjourn

Cathy Slemp, MD, MPH; Chair, BSC CPR

Before adjourning, Dr. Lochner thanked the BSC for joining and engaging in a vigorous discussion that has provided CPR with many things to consider when planning the purpose and work for the working group. The BSC will have its next meeting on March 29-30, 2023. This will be a hybrid meeting with attendance in-person and via Zoom. Later during the week, board members will be contacted regarding their availability.

Dr. Slemp joined Dr. Lochner in thanking the BSC for attending and for providing its valuable feedback and discussion that will aid in the drafting of the terms of reference for the workgroup. The next step is to draft the terms of reference, which will help the BSC provide more concrete concepts. BSC members may be contacted to ascertain if there is interest in leading or being a part of the working group. There will be two co-chairs. If anyone was interested in leading or being a part of the working group, they were instructed to contact Drs. Slemp or Lochner. Additional suggestions on BSC members, organizations, or individuals to be included in the workgroup were also welcomed.

With no further business to be covered, the meeting was adjourned at 2:54 PM EST.

CERTIFICATION

I hereby certify that to the best of my knowledge the foregoing minutes of January 23, 2023 virtual meeting of the Board of Scientific Counselors, Center for Preparedness and Response are accurate and complete.

4/13/2023
Date

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Catherine C. Slemp, MD, MPH
Chair, BSC CPR

APPENDIX A: BSC CPR Membership Roster

DESIGNATED FEDERAL OFFICER

Kimberly Lochner, ScD
Deputy Associate Director for Science, CPR
Centers for Disease Control and Prevention
Atlanta, Georgia

CHAIR

Catherine C. Slemp, MD, MPH
Public Health Policy and Practice, Consultant
Milton, West Virginia
Term: 2/08/2019 – 9/30/2022

MEMBERS

David Fleming, MD
Distinguished Fellow, Trust for America's Health (TFAH)
Bainbridge, Washington
Term: 11/07/2019 - 9/30/2023

Paul Halverson, DrPH
Founding Dean, Professor of Policy and Management
Richard M. Fairbanks School of Public Health
Indiana University
Indianapolis, Indiana
Term: 6/08/2022 – 9/30/2025

Jennifer A. Horney, MPH, PhD
Professor, College of Health Sciences
STAR Health Sciences Complex
Newark, Delaware
Term: 5/13/2021 – 9/30/2022

David Leroy Lakey, MD
Vice Chancellor of Health Affairs and Chief Medical Officer
The University of Texas System
Austin, Texas
Term: 5/13/2021 – 9/30/2024

Marissa J. Levine, MD, MPH
Professor, College of Public Health
University of South Florida
Tampa, Florida
Term: 5/13/2021 – 9/30/2024

Brent Pawlecki, MD
Chief Health Officer
Wells Fargo
New York, New York
Term: 2/12/2019 - 9/30/2022

Kasisomayajula Viswanath, PhD, MA, MCJ
Lee Kum Kee Professor, Health Communication
Department of Social and Behavioral Sciences
Harvard T.H. Chan School of Public Health
Boston, Massachusetts
Term: 2/15/2019 – 9/30/2022

EX OFFICIO MEMBERS

Assistant Secretary for Preparedness and Response
Kristin L DeBord, PhD
Director, Strategy Division
Office of the Assistant Secretary for Preparedness and Response (ASPR)
U.S. Department of Health and Human Services
Washington, District of Columbia

National Institutes of Health (NIH)
Paula Bryant, PhD
Director, Office of Biodefense, Research Resources, and Translational Research
Division of Microbiology and Infectious Diseases
National Institute of Allergy and Infectious Diseases
Rockville, Maryland

LIAISON REPRESENTATIVES

Christina Egan, PhD, CBSP
Association of Public Health Laboratories (APHL)
Chief, Biodefense Laboratory, Wadsworth Center
New York State Department of Health
Albany, New York

Alexia Harrist MD, PhD
Association of State and Territorial Health Officials (ASTHO)
State Epidemiologist and State Health Officer
Wyoming Department of Health
Cheyenne, Wyoming

Laura Magana, PhD
Association of Schools and Programs of Public Health (ASPPH)
President and CEO

Washington, District of Columbia

Benjamin P. Chan, MD, MPH
Council of State and Territorial Epidemiologist (CSTE)
State Epidemiologist
New Hampshire Department of Health and Human Services
Division of Public Health Services
Concord, New Hampshire

Michele Askenazi, MPH, CHES
National Association of County and City Health Officials (NACCHO)
Director, Emergency Preparedness, Response, and Communicable Disease Surveillance
Tri-County Health Department
Greenwood Village, Colorado

A. J. Schall, Jr., BS
National Emergency Management Association (NEMA)
Director, Delaware Emergency Management Agency
Department of Safety & Homeland Security
Smyrna, Delaware

APPENDIX B: Attendees List

BSC Members

Paul Halverson
Kathleen Tierney
Brent Pawlecki
Marissa Levine
Catherine Slemp
Jennifer Horney

Ex Officio

Paula Bryant

Liaisons

Alexia Harrist
Laura Magana
Christina Egan
Ben Chan

CDC Representatives

Henry Walke
Ian Williams
Lovisa Romanoff
Jay Butler
Chris de la Motte Hurst
Emily Eisenberg Lobelo
Kimberly Lochner
Joanne Andreadis
Monique Jester Williams
Magon Saunders
John Anderton
Chris Brown (CDC)
Lori Bane
Samuel Edwin
Lia Haynes Smith
Chris Kosmos
Kate Noelte
Dometa Ouisley
Clinetta Bellamy
Lorenzo Barr
Tangela Love
Rebecca Hall

Ada Quinones
Adora Nsonwu
Albert Garcia
Allison Watson
Amanda Evanson
Ana Ishikawa
Anderson Noelle
Andrew Laarhoven
April Bankston
Araceli Rey
Barbara Kitchens
Ben Hasselbring
Bill Howard
Braeden Benson
Brenda Zangwill
Briana Barnes
Brittany Grear
Caroline Ngure
Carolyn Tunstall
Chandra Lewis
Chaunte Stampley
Chisom Onyeuku
Christopher Reinold
Colin Shepard
Cynthia Davis
Daniele Ngantou
David Kennedy
Dylan Sorensen
Emily Imboden
Enitra Jones
Eric Mooring
Ernest Smith
Fakhteh Shahmirzadi
Federico Feldstein
Georgia Moore
Geremy Lloyd
Gerry Gomez
Gregory Sunshine
Gregory Smith
Gretchen Cowman
Habarta Nancy
Holly Gay
Jacinta Smith
Jamilla Green
Jana Austin

Janine Hines
Jarad Schiffer
Jeanne Ruff
Jeniffer Concepcion
Jennifer Gaines
Jeremy Ratcliff
Jie Feng
Johanna Gilstrap
John Bermingham
Judy Lipshutz
Kathleen Henderson
Katie Sives
Katie Fullerton
Katie Pugh
Katy Donovan
Kawi Mailutha
Kellee Waters
Kelly Dickinson
Kimberly Leeks
Kris Carter
Kristen Chapman
Kristina Stark
Kristine Camper
Kyra Perz
LA Miller
LaBrina Jones
Laird Ruth
LaNesha McCann
Larissa Joassaint
LaToshia Gray
Lilanthi Balasuriya
Linda Tierney
Linde Parcels
Lisa Caucci
Luis Poblano
Lydia Solomon
Mackenzie Mann
Marina Gibson
Mark Bracey
Mark Green
Mark Frank
Mary Leinhos
Matt Mauldin
Meg Freedman
Melissa Erkens
Melissa Morrison

Mimi Kothari
Miriam Hoppe
Mona Byrkit
Nastassia Laster
Olivia Edemba
Oluwatomiloba Ademokun
Onalee Grady-Erickson
Paramjit Sandhu
Peter Rzeszotarski
Phyllis Stoll
Rachel Avchen
Rebecca Sabo
Robin Soler
Rockie Rodriguez
Sachi Kuwabara
Sandra Steiner
Sara Vagi
Schell McCrory
Shauna Mettee Zarecki
Shaw Gargis
Shawnbria Ray
Shelly Stancil
Shimere Ballou
Shoukat Qari
Silvia Trigoso
Sonal Doshi
Stacey Jenkins
Stephanie Dopson
Taylor Coleman
Terrance Jones
Theresa Smith
Tiandra Thornton
Veneranda Ngulefac

Public Attendees

Abi Kinnard
Adaora Okpa
Alexander Tin
Amanda Cosser
Amy Walker
Ashley Holmes
Brenda Staudenmaier
Brooke Zollinger
Chad Chinich
Chloe Chipman
Chris Riotta
Deborah Isola

APPENDIX C: Acroymns

BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
COVID	Coronavirus Disease
COVID-19	Coronavirus Disease 2019
CPR	Center for Preparedness and Response (CDC)
CSTE	Council of State and Territorial Epidemiologists
DEIA	Diversity, Equity, Inclusion, Accessibility
HHS	United States Department of Health and Human Services
NACCHO	National Association of County and City Health Officials