CDC Advisory Committee to the Director (ACD)

Minutes from the February 21, 2024 Meeting

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Advisory Committee to the Director: Record of the February 21, 2024 Meeting

The Centers for Disease Control and Prevention (CDC) convened a hybrid meeting of its Advisory Committee to the Director (ACD) on February 21, 2024 in-person and via Zoom for Government and teleconference. The agenda included: 1) agency priorities and updates from CDC Director Mandy Cohen; 2) updates on public health accreditation; 3) mental health and overdose; 4) Center for Forecasting and Outbreak Analytics (CFA) update on progress to date and future initiatives; 5) Moving Forward update; 6) health equity update; 7) and proposed Communications and Public Engagement Workgroup (CPEW) update and vote.

Welcome, Roll Call, Memorium

Debra Houry, MD, MPH (ACD DFO) called the meeting to order and yielded the floor to the ACD Chair, Dr. David Fleming.

David Fleming, MD (ACD Chair) welcomed the ACD members, CDC leadership and staff, guests, and attendees joining virtually and briefly reviewed the agenda. He then called the roll, which established that a quorum of ACD members was present. Quorum was maintained throughout the meeting. The ACD Membership Roster is appended to this document as Attachment #1. No conflicts of interest (COIs) were identified. Dr. Fleming recognized and welcomed the ACD's newest member, Dr. Helene Gayle. Dr. Gayle said that when she received the call to join the ACD, she was thrilled as CDC was her professional home for 20 years. She thought if she could be helpful at a time that is critical in the life of CDC, she could give back and be as supportive as ever.

On a somber note, Dr. Fleming announced that missing from the meeting was one of ACD's longstanding members and a colleague and friend to many of them, Dr. Adora Adimora, who recently passed away since the last ACD meeting. He emphasized how much Dr. Adimora's presence would be missed. She served on the ACD Health Equity Workgroup (HEW) work group with him where he saw her in action. He had the good fortune to talk to her one-on-one about CDC leadership and communication. In that sense, Dr. Adimora's thinking formed the impetus behind the proposed CPEW they would hear about and vote on during this meeting. CDC and the ACD are fortunate for her to have left this legacy. Dr. Houry echoed the sorrow over losing Dr. Adimora. When speaking with her about leading the CPEW, Dr. Adimora mentioned that she had an illness but would do her best to champion and move forward. Dr. Houry noted Dr. Adimora's accomplishments in infectious disease and health disparities.

Director's Update: Agency Priorities

Mandy K. Cohen, MD, MPH (Director, CDC) welcomed everyone. She said she was thrilled that Dr. Gayle agreed to join the ACD and was looking forward to learning from her experience inside and outside of CDC to make the CDC as strong as possible. She echoed the sad news about Dr. Adimora, who was a fellow North Carolinian. Knowing Dr. Adimora's work from North Carolina and what a wonderful human being she was in addition to her incredible professional contributions, Dr. Cohen emphasized what a huge loss Dr. Adimora's passing is and stressed that she will be greatly missed.

Dr. Cohen emphasized how proud she is of the work that has been done by the agency over the past 8 months as it recovers from a historic crisis that has been the most intense readiness posture imaginable. The successes are clear in examples such as the organization's response to the respiratory season and operating as one team across CDC. It was not the influenza team and the respiratory team working separately. It was everyone pulling together from data, to laboratory, to workforce, to communications. She also is proud of CDC's Bridge Access Program, which is a public-private partnership to help maintain access to free COVID-19 vaccines for adults who are underinsured or uninsured through their local pharmacies, the existing public health infrastructure, and their local health centers. There also is data work underway to align data across diseases in order to be disease-agnostic. She expressed gratitude to Niall Brennan, CDC's Senior Advisor to the Director, and his team who did an incredibly fast and remarkable job that demonstrates where CDC wants to go in terms of putting great information in the hands of people so they can protect themselves and make good decisions for themselves and their families. There are some new vaccines available, respiratory syncytial virus (RSV) vaccines for adults and for pregnant moms, RSV immunizations for infants, and an updated COVID vaccine. In addition, the agency has spent a lot of time reminding folks to get their influenza vaccines.

Dr. Cohen recently returned from an international trip where she opened CDC's regional office in Tokyo, which is strategically important for the CDC in terms of building diplomatic alliances and ensuring that the agency has visibility in that part of the world. She also visited Cambodia where she saw how CDC's investment in global health is protecting Americans every single day. This was an opportunity to see firsthand the entire 22-year investment CDC has made in Cambodia, which is currently protecting Americans and preventing avian influenza from spreading in that region and then coming to the United States (US). She visited a bird market where they were swabbing ducks and running genome sequencing. She then talked to the doctors at the hospital where they treat avian influenza cases and went to the laboratory where they run the samples, and then met with the graduates from the Field Epidemiology Training Program (FETP) who go into the community to ask about symptoms. This is great public health work on the ground that was fundamentally built on the trust of those who CDC's FETP is training from the villages and is a reminder of the importance of how this investment is keeping the world safe.

Dr. Cohen spoke about how CDC allocated funds in the last year, to help transition from a pandemic response in which all of the attention and funding focused on the COVID response. CDC allocated $262 million to support the National Network for Outbreak Response and Disease Modeling and $390 million to support advanced molecular detection and national wastewater surveillance. Another $245 million was allocated to data modernization efforts, that went almost exclusively to CDC's state and local partners. While CDC's respiratory response is certainly top of mind, it is important to remember what CDC is doing to broaden people's understanding of what the agency is doing to protect health. With that in mind, $279 million was allocated to Overdose Data to Action (OD2A), which helps states track and understand opioid use and overdoses in the US. To highlight some of the work that is ongoing in terms of partnerships, CDC released "Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders"[1] in collaboration with the agency's education partners from whom they heard about strains on mental health. This is an example of turning data into action that people can use.

[1] https://www.cdc.gov/healthyyouth/mental-health-action-guide/pdf/DASH_MH_Action_Guide_508.pdf

Looking at CDC's internal organization, about 75% of the Moving Forward actions have been completed, and the agency is moving into the next phase of this initiative. The Leadership Team wants to consider immediate goals that will continue to build toward strengthening CDC's unique role in protecting health and improving lives. That is the big vision of getting to an effective and efficient CDC that is protecting health, improving lives, and showcasing readiness work, expertise, and investments in communities around the country—2024 is about ensuring that CDC is focusing on key areas that deliver on that promise. The first priority focuses on readiness and response to health threats and ensuring that the CDC is investing in the critical infrastructure and core capabilities that allow the agency to respond no matter the threat. The next threat could be a respiratory virus or an environmental threat. CDC needs to be ready for whatever that is and its platforms must be flexible and robust enough to support that. Laboratory capabilities must be in place, the data infrastructure must be sufficient to detect and respond, and the workforce must be trained on an ongoing basis and ready to deploy. This is a whole-of-agency response that is "disease-agnostic" in order to build toward the best CDC possible. In terms of readiness and response, CDC is "the quarterback" as the lead in the US Government (USG) in response to health threats. The second priority is improving mental health. This is where CDC's data and expertise in best practices can help drive improvement and reduce suicides and overdoses. This involves collaboration with partners like the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), state partners, and the medical community. The third priority is supporting young families. This is where CDC's prevention work shines in terms of intervening upstream as early as possible in order to prevent something. This is about moms having healthy pregnancies, the first few years of brain development, immunizing children, promoting food security, addressing the challenges faced by caregivers and parents, diabetes prevention, et cetera.

Dr. Cohen is calling the next chapter of Moving Forward "One CDC." Her vision is for the agency to operate as one team. That means having a world-class and diverse workforce, training, recruiting, continued partnerships with Historically Black Colleges and Universities (HBCUs) and others, equity, accountability, and modernizing communication internally in addition to externally. She is excited about the investments CDC is making internally because they will help the agency excel in data, laboratories, and workforce. From a communications standpoint, there is a major change coming in CDC's web presence, which is one way the agency interacts externally with others. The agency is very close to launching "Clean Slate" which involves archiving a ton of information that is not readily accessible to make actionable information more prominent. She is excited for the opportunity to reintroduce the CDC to the public to show how CDC is working in people's own backyards to protect families' health, children, mental health, caregivers, heat, et cetera. She and Dr. Houry have asked the ACD to think about a new working group (WG) that focuses on partnerships, engagement, and communication. While CDC has expertise in science and data, it also is foundational to be experts in partnering and communication. Many people came to know CDC due to COVID. The agency must reach the public in a trusted way with important key messages in order for people to change their behaviors. Behavior change is hard, so CDC has to be the best at it and think strategically about how to partner better to do this at the community level and with national partners in order to bring the agency's efforts to scale. Dr. Cohen emphasized that CDC is seeking advice and assistance in terms of how best to structure that internally to support the agency's work and envision what that looks like when CDC is doing that really well.

Discussion Summary

Dr. Martinez expressed appreciation for CDC's concentration on mental health. This brought to mind suicide rates across the US and the critical element of access to dangerous weapons, given that most suicides are gun-related in this country. He asked Dr. Cohen's thoughts on how this could be turned around. Suicide is often impulsive and half of almost all suicides are secondary to the use of guns. He viewed this as an area where public health could make a huge impact and save many lives. In terms of behavioral health, it is known that those who survive a suicide attempt can still lead fruitful lives. This is a critical moment in time.

Dr. Cohen pointed out that suicides with guns are even higher for men. She referred to a *New York Times* article that laid out why taking away a method of committing suicide does not mean someone will find another means. This is another paradigm shift that people need to understand and is what CDC data has been showing. As much as guns can be a more challenging issue to work on, she hears a lot of consensus in terms of focusing on suicide and gun safety. CDC is going to have to lean into a focus on gun safety. There are a number of ways the agency already is supporting best practices, such as understanding the impact of red flag laws, where they are implemented, and the best practices. There are many ways that the agency can bring data and best practices to this issue, which is where CDC shines and will focus.

Dr. Fleming noted that early in his career, he did some work in Oregon on adolescent suicides and found that guns were an overwhelming predictor of whether a suicide attempt was successful. He agreed that this is an issue around which some consensus is possible.

Dr. Sharfstein said he worked with the team that works on the red flag laws at Johns Hopkins University (JSU) on Extreme Risk Protection Orders (ERPOs) to conduct Grand Rounds in a number of clinical environments. There is an interest among clinicians because it is scary to them when they see people at risk, particularly youth. In some states, physicians are able to file protection ERPO. There is a growing set of best practices and surveys for that, which provides an interesting opportunity to leverage the clinical community for a public health goal. He thanked Dr. Cohen for the strategic focus she is bringing to CDC. In addition to bringing a strategic approach, she is modeling the energy that the CDC needs. He wondered whether she had thought about the way CDC makes decisions on difficult topics and whether there are opportunities for improvement there. For instance, the agency has been stuck in a swirl of competing news stories about COVID guidance that may or may not be coming out. This is a classic situation in which everyone is angry about a statement from CDC that has not yet made but for which there is rampant speculation. He asked whether she is considering how these phenomena come about and how she is thinking about that.

Dr. Cohen said that CDC is working hard to change the decision-making processes within CDC. That starts with working differently as a team. The previous day, the senior leadership conversation focused on how to align strategies across CDC as opposed to each center developing its own strategy, which keeps CDC siloed. The questions must be asked and planned together at the senior leadership level about how to invest in data, how to invest in the laboratory structure, how to train the workforce, what priorities should be set, and so forth. The agency has implemented new processes around policy development. For example, the guidances that have been developed in the last 6 months have been put out for comment and feedback, and a much different level of engagement is being utilized in that process. Specific to COVID, which is sensitive, CDC was not ready to share something. The fact that information was in the public without context was disappointing. CDC wants an inclusive and collaborative process, but also need the time and space to do that work. It is a hard balance, especially in terms of COVID. In addition to moving in the direction of different processes internally, consideration also is being given to the process for obtaining collaborative feedback from external sources and other kinds of guidance.

Dr. Morita expressed appreciation for the strategic approach and the way in which Dr. Cohen described the work and identified that the CDC is the “quarterback” in some situations and a partner in others. She asked how COVID’s disproportionate impact on marginalized communities is being considered in CDC’s planning. Many are backing away from the use of diversity, equity, and inclusion (DEI), but these communities are more impacted.

Dr. Cohen responded that equity work has to be embedded in everything CDC does. The agency has the Office of Health Equity (OHE) and ways of thinking about programmatic equity work and internal CDC DEI work. She calls it “belonging” and talks about it from a values perspective that everybody belongs, but it has to be owned by

everyone. The Health Equity Team cannot own that for everyone at CDC and then that it is done. She commended the CDC for being the most equity-focused organization she has had the privilege of being part of. She sees it everywhere she looks within the agency, but where they need to continue to do better is in understanding the realities of the community. It is not enough to ask the questions and think about interventions. It involves good operations and good operations are equity work. For instance, vaccine access is not only about collecting good race and ethnicity data, but also it regards thinking about it in a systemic way in terms of how the programs touch different communities, how the access points work in terms of manufacturing and shipping, what the access points are, what the price points are, who is talking about it. Her focus is more on equity operations because she is an operations person, but she wants to see that more reflected in the agency's operational work. CDC is already doing terrific work in the equity space, but her focus for this year is on getting it into the operations space.

Ms. Valdes Lupi said she is particularly interested in how Dr. Cohen is approaching the work on the interactions of heat and health. Picking up on what Dr. Cohen lifted up in terms of operationalizing equity and seeing equity in action, a great example for someone like her external to CDC is to see the work in the development of the Environmental Justice Index (EJI). She asked Dr. Cohen to expound on how she would consider the work of climate change, health, and equity.

Dr. Cohen responded that CDC is placing a focus on the intersection between health and heat this year, with a focus on what CDC does best—making sure the agency has good data for folks to build upon to make good decisions. They are working toward ways for everyone to be able to see a heat index. She learned the previous day that 94 degrees in Miami is not the same as 94 degrees in Vermont. It is important to understand how temperatures impact people, how the environment is changing, and how pathogens are reacting to that in terms of vectors such as mosquitos and ticks, as well as what pathogens are getting defrosted at the North Pole. The infectious disease component of heat is important. CDC has some foundational "blocking and tackling" to do in terms of getting the data right, getting the detection surveillance work in the right place, and building upon that to determine the most important steps to take. While Dr. Cohen recognizes that they have some work to do, CDC is excited about the potential in this space because this is part of fulfilling the agency's mission to protect health and improve lives. With 2023 being the hottest year on record, CDC must do more in this space because the world is changing and she agreed that there also is an environmental justice aspect of building and moving this work forward.

Dr. Gayle applauded the priorities and clarity coming out of a time in which people stopped understanding the CDC's mission and role. In terms of One CDC, it is hard in any organization to say the organization is prioritizing and not have other parts of the organization think they have been forgotten. Some things get lost that also are still important. Given the fact that equity is not necessarily strongly stated up front, it will be important to make people understand. She thought Dr. Cohen's description of an operational way of thinking about that made sense, but it will not make sense to a lot of people because it sounds like it is getting demoted. The framing of mental health issues is great in thinking about it in terms of suicide, overdose, and issues that people agree on. However, the issue people will not agree on is homicide and gun control no matter how hard the agency tries to keep in boxes that people feel more comfortable with. CDC must be prepared for the fact that there are people who will feel like the agency is turning its back on a large issue and others who will try to pull CDC in. Consideration must be given to how the agency wants to position that and think about the communities that are impacted to make sure people do not feel forgotten, but still not get itself embroiled in whatever issues. She wished CDC good luck on that dance. Regarding mental health in schools, she is in an institution of higher learning where this is a huge issue. She wondered how Dr. Cohen was thinking about schools, what levels, and areas for potential partnerships.

Dr. Cohen replied that the Leadership Team thought hard to make to make sure the priorities feel elastic enough that everybody sees themselves in them, particularly in terms of thinking about One CDC with a worldclass workforce that is diverse, focused on equity, is accountable, and is communicating well. That includes every single person at CDC no matter where they sit. CDC's mission to protect health is very aligned with being ready to respond. She expressed gratitude for the good feedback to make sure that health equity is more strongly stated and on violence and homicide and how to do that work. Her experience in North Carolina, working for a Democrat Governor and a Supermajority of Republicans, was that they first aligned on the issues where they found consensus. The way she is thinking about it is to start with consensus, build trust, and put some "wins on the board" so CDC can show that they can work together. Then they take the next step and next step, at least through her tenure there, as she navigates to ensure that CDC has what it needs to continue the work. While they are articulating priorities where she sees more consensus, that does not mean that there are not other things they want to do in the future. Her hope is that the priorities allow them to build a foundation of showing that they can work on hard things together and then move forward from there. In terms of mental health and schools, she deferred to the presentation Dr. Houry would be delivering later in the day.

Dr. Taylor expressed gratitude for all of the work CDC has done with respect to laboratories and the great deal of progress that has been made but noted that there is more to do and that CDC needs funding for that work. As a virologist, she is worried about the current measles outbreaks worldwide. Polio also scares her, but it is not clear whether people remember polio. Vaccine rates keep declining, but the issue of vaccine mandates is a very sensitive subject. While this is a difficult subject at the moment, it is not one that CDC can avoid. Since Americans do not like being told what to do, consideration must be given to how to convey the pros and cons in a way that is not "in-your-face" and confrontational. The aim must be to do better rather than trying to be perfect, because any progress that can be made in increasing the vaccine rate is worth doing. Perhaps this could be a subject for the proposed CPEW, because there needs to be a broader conversation about how to do better as a country.

Dr. Cohen responded that CDC is tracking the measles issue closely. Not surprisingly, the cases are among those who are not vaccinated. In terms of polio, CDC continues to be strong partners in the polio eradication work. There is a lot more work to do, even with the global investment that is being made in that space. The reality is that people have forgotten, which is sad because these diseases are so serious. She thought it would be a great opportunity for the new CPEW to consider how to continue to help people understand the messages in the context of not seeing cases.

Dr. Fleming said it was always a delight to have Dr. Cohen attend the ACD meetings and that he is always impressed about how wide-ranging the questions are. While the questions are tough, she is doing a great job addressing them. He appreciates the notion of One CDC, which is something the agency has recognized and struggled with in the past, in part because of the categorical nature of the funding comes into the CDC, which creates natural silos. The same dynamic plays out at the state and local levels where health departments tend to be an amalgamation of individual programs rather than being unified organizations, in part because of the funding process. He wondered what consideration CDC has given to recognizing that one of the barriers at the state and local levels is the categorical nature of funding and the difficulty of using those funds across a state and local department to make the right things happen.

Dr. Cohen said she thinks about this often, especially as someone who came from North Carolina where she was Secretary of the North Carolina Department Health and Human Services (NCDHHS). She had the opportunity to bring together public health, Medicaid, mental health, and early childhood dollars and they planned together to braid funding together but understands that this is not the reality of every state. Leaders are needed who are willing to sit at the table and braid funding, which requires a huge level of trust between people who work together. That did not happen overnight in North Carolina, and it is hard when there is only a certain amount of

money and people feel that "it's mine." It is very challenging, but very doable. For 2024, CDC has very much focused internally on how to do that better. If they want to see this at the state level, CDC has to be a role model first and foremost. The agency's budget structure will not change overnight, so the Leadership Team must come together and figure out how to do this within the constructs that exist. Even in terms of data investments, every program needs critical infrastructure or core capabilities. Every program needs data, but the agency has hundreds of data systems because every individual program built their own. Not that one is bad and one is good. CDC has to right-size that for the effectiveness and efficiency of agency's budget. But it is hard because it requires change and the investments in dollars in a different way. The Leadership Team is going to work through this the best they can internally and then has to have conversations with Congressional partners and appropriators. They already have had conversations with Congressional partners and appropriators to talk about investments in critical infrastructure and core capabilities (e.g., data, laboratory, workforce, and response capabilities, global work). This does not mean she has taken her "eye off the ball" in terms of tuberculosis (TB), avian influenza, or human immunodeficiency virus (HIV). It means that things can go forward with a stronger platform that is interoperable and extensible. While this must be chipped away at over time, there is a down payment for that in the 2024 plan.

Dr. Fleming said the ACD is looking forward to working with Dr. Cohen on that. The Data & Surveillance WG (DSW) is helping to grapple with that in terms of the number of data systems. Some of the issues around health equity and equity can provide a unifying focus across different programs where co-investment in resources would make a huge difference as well. On behalf of the ACD, he thanked Dr. Cohen and stressed that it is always heartening to hear her speak and see the progress that has been made since she assumed leadership of the agency.

Dr. Cohen said she has read every one of the WG reports to make sure the agency is taking the smart advice from them. She is excited about the launch of the new CPEW to help further this work. Recognizing how busy everyone is, she expressed appreciation for the time the ACD and WGs are investing in this.

Public Health Accreditation

Leslie Ann Dauphin, PhD (Director, National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce [PHIC]) presented on the topic of accreditation, pointing out that CDC plays a major role in supporting public health departments through direct funding, support of partnerships, and by providing tools and technical assistance (TA). The National Voluntary Accreditation Program is managed in CDC's National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce (Public Health Infrastructure Center) and in the Division of Partnership Support (DPS). During this session, Dr. Dauphin provided an overview of the program, CDC's investments to support this program, the current state of accreditation by the numbers, and some evaluation findings.

Accreditation of health departments is about standards and measures that are intended to raise performance and reflect current public health practice. These standards and measures are organized into 10 domains and are aligned with the 10 Essential Public Health Services (EPHS), which is a framework that promotes policies, systems, and services to enable good health. The latest version is "The Futures Initiative: the 10 Essential Public Health Services" that was developed through a collaborative effort involving the de Beaumont Foundation, the Public Health National Center for Innovation (PHNCI), and a Task Force of public health experts that was established in 2019 with a primary goal to align the 10 EPHS national framework with the evolving needs of current and emerging public health practices. The new framework includes health equity considerations that are embedded in every domain, and the foundational capabilities also are embedded. These standards include some major activities that health departments should give attention to while they are working on improving the services they provide.

For accreditation, health departments are required to use either documentation or a peer-review process, and it also involves site visits. Once achieved, accreditation is good for a period of 5 years, at which point the health department can seek reaccreditation. The reaccreditation process is somewhat more streamlined with fewer standards and measures while also assessing that the health department has continued to make process. That is, it is about continual quality improvement. This is a voluntary program for which the Public Health Accreditation Board (PHAB) serves as the accrediting body. Following some recommendations in a 2003 Institute of Medicine (IOM) report, CDC and the Robert Johnson Wood Johnson Foundation (RWJF) played key roles in sparking an exploratory process into what accreditation looks like. In terms of the timeline, the National Voluntary Accreditation Program was established in 2007, the PHAB was established in 2007, the program was launched in 2011, the first health departments were accredited in 2013 for 5 years, and those first health departments were reaccredited in 2018.

The CDC has funded the program through cooperative agreements and providing support to help health departments achieve accreditation. CDC has consistently invested in accreditation activities since about 2005. In terms of CDC's PHAB cooperative agreement funding, the first cooperative agreement (HMO8-805) was funding to national partners, of which PHAB was one, to address public health infrastructure and core activities, including accreditation and performance standards. Since that time, CDC has invested in successful sole-source cooperative agreements to the PHAB. Since 2013, there have been 3 different sole-source cooperative agreements to PHAB (OT13-1301, OT18-1801, and TO23-0002). RWJF also provided funding and support for accreditation. Through collaboration with CDC, RWJF implemented some complementary strategies that contributed to national accreditation success. For example, CDC worked on supporting the use of these national standards while RWJF supported the development of new quality improvement tools.

Almost all state health departments are accredited. Of the more than 2,000 local health departments, approximately 17% (389) are accredited and more than 80 are currently pursuing accreditation. With regard to tribal health departments, 6 health departments are currently accredited by PHAB and 9 are in process. It is important to highlight that PHAB has contracted work with the Department of Defense (DoD) to accredit all army installation departments of public health, so this has extended beyond state, tribal, local, and territorial (STLT) public health departments. Internationally, the Ministry of Public Health (MoPH) in Qatar received the first PHAB accreditation outside of the US.

There are 111 health departments that are either engaged in or eligible for reaccreditation. From 2020-2023, there have been 5 states, 61 local, and 2 tribal health departments that have achieved accreditation status. The pace has slowed but has reached a point at which fewer state health departments are not accredited than are accredited. Between 2021-2022, an average of about 24 local health per year achieved accreditation. That number has decreased somewhat to about 10 per year in part because PHAB granted extensions of accreditation activities to health departments in response to the COVID-19 pandemic. Extensions were common in the past few years and may now account for some of the changes in pace that have been observed, particularly at the local health department level.

Since 2013, NORC at the University of Chicago[2] has conducted surveys of health departments when they have reached important milestones at 1-year post-accreditation, 4 years post-accreditation, and throughout the re-accreditation process. The purpose is to collect data from health departments to learn about the process, inform process improvement, and document outcomes to inform decisions about the future state of the program. The respondents are health departments that registered for accreditation and those that are accredited. The results are self-reported and offer an opportunity to share successes and opportunities for improvement. Approximately 95% of 281 respondents reported in a 1-year post-accreditation survey indicated that they saw improvements in quality and performance. Similarly, 88% of 291 respondents indicated accountability and transparency from the same set of data. About 53% of 204 respondents reported in the 4-year post-accreditation survey that relationships with new partners have been helpful. With regard to reaccreditation, 31% of 77 respondents reported a decreased perceived value or benefit as a challenge of re-accreditation. Challenges identified regarding reaccreditation have been related to staff time, turnover, and leadership. Challenges reported from the state and local levels are that there are some burdens perceived with regard to the cost, amount of time, and effort required to achieve accreditation.

Discussion Summary

Dr. Sharfstein commented that the pandemic caused a lot of introspection in public health in terms of huge variation in public health structures and responses across the country. He wondered whether there has been that same kind of introspection about accreditation. A number of places that were trumpeting their accreditation struggled during the pandemic. Some of the After-Action Reviews (AARs) have been brutal about the ability of some accredited health departments to do basic things. He appreciates completely the idea that there has been a huge focus on quality improvement, which is seen in the NORC report. While he was not in any way trying to say that public health accreditation is not valuable, he wondered whether there had been introspection. States are able to get accredited even if a lot of local health departments in the state are not accredited, and even if there is not the foundational coverage of the state. Accreditation tends to be organized to what the state is doing, but not so much on services or coverage the people in the state can count on. He supports accreditation, but wondered if that kind of introspection could manifest itself completely in CDC soliciting potential changes to accreditation based on the experience of the pandemic. He wonders if continuing with the same play book makes sense given what was learned in the pandemic.

[2] https://phaboard.org/wp-content/uploads/Assessing-Effects-of-PHAB-Accreditation_Final-Evaluation-Report_Final.pdf

Dr. Dauphin responded that there has been a lot of consideration internally about how CDC can assess whether accreditation is really helping public health agencies improve the quality of their services. States health departments may receive accreditation, but local health departments that work at the community level may not. The PHAB has funded 3 impact studies to assess exactly what Dr. Sharfstein asked about. One study is examining the impact of accreditation in different areas such as Ohio, which is the only state that mandates accreditation of their local health departments. Another study is assessing the experiences of accreditation among small local, rural, tribal, territorial, and Freely Associated States (FAS) to determine whether they are really meeting the needs of those communities. They recognize the diversity among health departments and the services they are able to provide.

Dr. Morita noted that she has a perspective about accreditation because she went through the process with one of the first large city health local health departments that got accredited and reaccredited. Accreditation is a process for demonstrating that health departments can do certain things. In some ways, she felt like the process was a box-checking activity. The real question regards what the 10 essential services or core capabilities are that all public health departments should have. This is less about the siloed activities that are happening in the different parts of the organization, but what holistically an effective public health department needs to have and whether there is a role for CDC to play in ensuring that those health departments have the core infrastructure that is necessary for them to be effective. In Chicago, they would receive siloed funding based on particular diseases processes or issues. What they lacked was core infrastructure funding to support the basics. There was a time when CDC did provide that type of support when they were accredited the first time, which was incredibly valuable. Then the funds went away and they returned to their siloed way of working. Maybe the role is not about CDC and accreditation as much as it is on what CDC's role is in ensuring that state and local health departments have core capacity that they are not getting from the state and local funding.

Dr. Dauphin acknowledged that funding is probably one of the biggest challenges. CDC agrees that there should be standards and measures, and that accreditation is a way to measure whether a public health department has achieved those measurements or standards. CDC's role in helping health departments achieve a level in which they can support and protect the health of their communities is what this is all about. With regard to funding, one of the ways CDC can try and would love to continue to support at the state and local levels is through the funding that supports building the public health infrastructure so that they can provide the core capabilities. One of the ways CDC is able to do that is through a very small and new appropriation that helps state and locals have the funding to build their capacity in the areas they see fit. This is through the Public Health Infrastructure and Capacity line. CDC knows that what is needed is more sustained funding to help state and local organizations build their infrastructure and their capacity to serve their communities in the ways that they can do so to meet their needs.

Mr. Dawes noted that he visited health department leaders in the US Virgin Islands (USVI) and Puerto Rico (PR) last fall and was curious about whether this program allows territorial health departments to join and if not, what the barriers have been for them. He was struck that while there is a total of 2309 local health departments, only 389 are participating in accreditation. He wondered what the top 3 barriers are for those who have not sought accreditation.

Dr. Dauphin noted that CDC is trying to help territories, FASs, and others achieve accreditation is through the Public Health Infrastructure Grant (PHIG) program, which she briefed the ACD on previously. Only territory in the process of trying to receive accreditation currently, but they have unique challenges that comes down to having sufficient capacity to go through the process of accreditation. This is true at the local level as well. The second challenge is funding. CDC is supporting PHAB and other mechanisms, such as the PHIG grants, to get funding out to help encourage and incentivize seeking accreditation. CDC is diving deep, but this is a

complicated, large, and challenging approach. This is why engaging the ACD is very helpful. CDC is interested in understanding things CDC can provide support at the local level and others who are facing unique challenges.

Dr. Gayle asked what lessons were learned having gone through one accreditation and reaccreditation and whether there were things CDC would consider modifying or evolving in some way to make it more effective. Clearly, the real goal is building capacity at the state and local levels and one of the biggest barriers is insufficient resources. She wondered what could be done in terms of educating those who could provide funds in order to elevate the core importance of this.

Dr. Dauphin stressed that PHAB continues to document and learn from the challenges and successes of those who achieve accreditation. NORC continues to conduct surveys, so CDC continues to hear from the health departments and that will help with the latest version of standards and measures to be released in 2027. This is a field-driven process. CDC documents the processes learned through evaluation, direct engagement at the state and local levels, and from what CDC's partners are learning. The biggest challenges CDC is hearing about is workforce challenges facing state and local levels. They simply do not have the people it takes to implement some of the requirements for accreditation or to go through the accreditation process. Through the PHIG program, CDC is providing funding to support workforce at the state and local levels. In addition, CDC tries to educate as much as they can, particularly on Capitol Hill, about the need for sustained funding to support the public health workforce. CDC also works closely to help partners understand that they also have a part to play in educating as much as possible about the need to sustain the public health workforce. Without those boots on the ground folks at the state and local level, none of the work can be moved forward.

Dr. Taylor noted that post-pandemic, many laboratories are assessing what they do in terms of whether the current menu of testing is appropriate for the world today. The Association of Public Health Laboratories (APHL) has been working on a strategic planning process to determine whether the menu of testing is appropriate. In many cases, laboratories have been testing X for 20 years. Should they still be doing that or is that something that can be contracted out, more inexpensively, to a high commercial laboratory? Their readiness capability is not good. She wondered if there is a step before accreditation in terms of thinking about supporting the laboratory community and then accrediting based on what they should be doing rather than what they are doing now. She went through the accreditation process in New York and to a large extent, it was a check the box and questions that did not relate to them as a laboratory in the health department.

Dr. Dauphin stressed that they could talk separately at length about the laboratory part. She has a background in laboratory science and worked for AHPL for years. The accreditation process could, and should, be about the capabilities that health departments should have no matter what their level (state, local, tribal, FAS) to support and protect the health of their communities. PHAB created a pathway process in which a health department may have some difficulty in achieving the standards and measures outlined through the full accreditation process. The pathways approach is a more streamlined way to determine the basic capabilities a health department with difficulties should have to support their community. It is another track to help health departments look at accreditation while they are looking at capabilities for which they may not be able to achieve the standards right away.

Dr. Medows asked whether CDC is working with the Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NACCHO) to provide TA to local health departments.

Dr. Dauphin indicated that CDC partners with both ASTHO and NACCHO in a variety of ways, one of which is in support of state and local health departments by providing tools and TA. ASTHO is a major funded partner as is PHAB through the PHIG. Through the PHIG, CDC has tried to incentivize accreditation and encourage use of the

funds to achieve accreditation. CDC is planning to ask those not interested why they are not interested, what the barriers are, and what CDC can do to help.

Ms. Valdes Lupi noted that previously she was at a large urban health department that got accredited before COVID. It was more than a check box exercise and was an all-hands-on-deck operation to keep the emphasis and focus on preparing for accreditation and eventually becoming accredited. In terms of the data Dr. Dauphin shared about the decreasing numbers during the pandemic and after COVID that are becoming accredited, she wondered whether there is a connection between incentivizing or encouraging accreditation as a way of gaining credibility and trust among community partners, policy makers, and other partners with whom the health departments have to work daily. She wondered what other ways could be explored through PHIG and other resources through the cooperative agreements to tie accreditation back to regaining or building trust and creditability and communicating the great work health departments have been doing.

Dr. Dauphin responded that one of the ways in which they try to educate officials is by highlighting CDC's support of accreditation because they recognize that policy makers understand standards, measures, and external bodies coming in to say that an entity has achieved a level of standard. Certainly, CDC uses every opportunity possible to talk about tying this back to credibility. In terms of incentivizing this with the funding provided through the PHIG and the cooperative agreements that have been used to fund PHAB, a lot is done at the state level to help incentivize their local health departments to help achieve accreditation in terms of additional funding, and TA.

Dr. Martinez asked whether interoperability is part of the accreditation standard and/or part of the standardization on what needs to occur in public health departments across the US, and whether it is an incentive to be accredited because of the focus on interoperability, data sharing, and ensuring that all levels of health departments can take care of their communities.

Ms. Liza Corso (PHIC) replied that there have been increasingly rigorous levels of expectations around data, data sharing, data use, and what they are showing with systems with the successive versions of the national standards. With the last version of the accreditation standards, CDC worked closely with individuals and experts from the Data Modernization Initiative (DMI) and the Office of Preparedness and Response (ORR) to ensure that there was synchronization of the expectations around preparedness, surveillance systems, data modernization, and interoperability opportunities. The accreditation standards are considered to be a tool for moving in the right direction and as a leader, for CDC to further advance the DMI interests and opportunities. The same point can be made with other areas the accreditation content has increasingly addressed, such as health equity, workforce training opportunities, and partnership development. It has been a "raising of boats" and continuing to "raise the boats that are already on the ocean." This gets them to the incentive point for those that are accredited in terms of application processes or connections with expectations in Notices of Funding Opportunity (NOFOs) for grantees and how that might relate to something that they already are doing for accreditation or vice versa.

Dr. Dauphin added that ideally, CDC would like to see the efforts working together. CDC has established a new Grants Governance Board to support the field, either through streamlined processes or learning from what they are hearing from the field to ensure that CDC is doing their best, and working with colleagues on the DMI and collaborating to think about the funding that is allocated, standards and measures, partnerships, TA, data, and readiness that should be working together to support the field and achieve the capabilities to help best serve and protect the communities.

Dr. Fleming noted that he had the opportunity to hear Dr. Dauphin speak on this before and wanted to gently raise the issue of whether this program is being evaluated correctly. In the early years of accreditation, he was

the State Epidemiologist in Oregon. While Oregon has wonderful public health workers, it has a mix of health departments. Some are highly competent and some in rural and frontier areas that are not sufficiently financed to provide core services despite how good the workers are. He was not sure that the goal should be simply to get all health departments accredited. Instead, it should be about how to ensure that health departments have foundational capabilities present that would enable accreditation. Currently, many health departments do not have foundational capabilities and should not be able to get accredited. In terms of evaluation of accreditation, he is not convinced that the process of going through accreditation is necessarily going to make a health department better. They should be able to show that there is a difference between health departments that are accredited and those that are not, such as the accredited health departments being able to provide the 10 essential services.

Dr. Dauphin noted that the studies PHAB has underway are assessing impact, but believes those studies are directed toward health departments that already have achieved accreditation. Dr. Fleming's suggestion about evaluation is something to take into consideration.

Mental Health and Overdose

Debra Houry, MD, MPH (Chief Medical Officer and Deputy Director for Science and Program, CDC) noted that as Dr. Cohen mentioned, one of the agency's priorities is mental health and overdose. This builds nicely off of the work that the National Center for Injury Prevention and Control (NCIPC, Injury Center[HL(1]) did years ago when they stood up an Opioid Response Coordinating Unity (ORCU) that has now morphed into the Behavioral Health Coordinating Unit (BHCU). The purpose of the BHCU is to pull work and strategies from across the agency into a unified approach. The BHCU is in the incubation stage but will lead a lot of these efforts once permanent leadership is put into place over the next couple of months. Collaborative initiatives and substance use will be part of this. Similarly, NCIPC and CDC participate in a lot of the HHS efforts. The Substance Abuse and Mental Health Services Administration (SAMHSA) leads on services and the National Institutes of Health (NIH) leads on research. CDC brings much of the data and community-level interventions and co-chairs the Suicide Prevention WG as part of the BHCU. One thing that she and Dr. Arwady will be tackling are the data systems related to drug overdose and mental health data to determine what systems they can tweak to be timelier and more forward-facing with dashboards and visualizations that are interactive. In addition, they will assess NOFOs in terms of how these are being evaluated and can be nimbler to address evolving changes. They also have assessed research priorities across the agency to understand what progress is being made on those. That is how this fits together as an agency-level approach.

Allison Arwady, MD, MPH (Director, National Center for Injury Prevention and Control) emphasized how excited NCIPC is about improving mental health being one of the priorities for the agency. This reflects where the country is, what the needs are and what the gaps are. NCIPC has 3 priority areas that clearly touch, contribute to, and are affected by the mental health priority, which are overdose prevention, suicide, and adverse childhood experiences (ACEs). The goal for NCIPC is to move data to action in terms of the Injury Center overall and for mental health specifically.

Overdose is an enormous and growing problem. There are 112,000 overdoses annually according to the most recent data, which is more than 300 deaths per day. This is the number one cause of death for adults 18 to 45 years of age and is only getting worse. A paper published in the last couple of weeks showed that in 2010, for every 20 times people were presenting to emergency departments (EDs) for non-fatal overdoses, there was 1 fatal overdose. Between 2010 and 2020, that ratio is 10 non-fatal overdoses in the ED for every fatal overdose. Illicit fentanyl is driving and making the drug supplies and drug use much more dangerous than it has been.

There is much more combination with stimulants such as methamphetamines in the West, cocaine in the East, and counterfeit pills. This increases the likelihood of overdoses ending in fatalities. Therefore, it is increasingly important in the prevention space to be thinking upstream, preventing overdose, and staying on top of data.

One of NCIPC's flagship programs and cooperative agreements is called Overdose Data to Action (OD2A). The first release of OD2A was in 2019. The Injury Center released a second round in September 2023 and is now funding all of the states that applied, with the exception of North Dakota, and 40 local jurisdictions or territories. This grant is almost $280 million, which is money to build the infrastructure and the OD2A work on the ground. As a former recipient in Chicago, Dr. Arwady emphasized that this funding was critical to establish basic epidemiology capabilities, building partnerships, and experimenting with what data could drive the needle. There are many examples of how people are using this funding to make data more timely, comprehensive, and actionable and then building in the evaluation components. One example is from a parish in Louisiana where the hospital EDs, law enforcement, first responders, the coroner's office, and the Harm Reduction Team (HRT) were pulled together to close the gaps, with a focus on ensuring that everyone was going home from the hospital with naloxone. The next year, there was a 35% reduction in overdose in that parish. This is an example of what NCIPC wants to see on the ground. In addition to the funded work, the Injury Center has been working to make sure that they are lifting up the best evidence for communities and partners to use.[3] What used to be known as "Technical Packages" are being rebranded as "Resources for Action." The idea is that there are things in the overdose space that work and have good evidence and there are things that do not work very well and do not have evidence. Where states and locals are receiving opioid settlement money, NCIPC wants to make sure that the decisions they are making is going into evidence-based prevention work and is using an OD2A framework.

Suicide prevention is not going well in terms of outcomes. There are approximately 49,000 suicide deaths annually, which is an increase of 2.6% from 2021 to 2022. Suicide deaths are increasing by approximately 2% to 3% per year just like overdoses. That is about 135 suicides every day in the US. A sobering statistic from Youth Behavioral Risk Survey (YBRS) data in 2021 showed that 1 in 10 high school students reported that not only had they thought about suicide, but also actually attempted suicide. It is known that suicide lands disproportionally on certain groups (e.g., veterans, rural populations, men, tribal populations, and youth). In terms of D2A funding, there are 24 comprehensive suicide prevention recipients. These grants total approximately $21 million in fiscal year 2023 (FY23), which is less than 10% of the overdose work, but it is critical. In terms of data, recipients are able to access ED syndromic data for those who present for suicide ideation or suicide attempts. This will allow people to receive the treatment they need to stop them from becoming a completed suicide. There is a lot of work focused on removing stigma to ensure that healthcare providers (HCP), coaches, faith leaders, teachers, and others have more ability to talk about and recognize this.[4]

CDC is very focused on preventing suicide. It is known that mental health is not the same as suicide. A mental health condition is a contributor to suicide a little more than 50% of the time. There also are impulsive issues (e.g., relationship problems, job loss, monetary concerns) that often drive a decision around a suicide attempt. As the lethality increases of what people may be choosing, completed suicides may increase as well. One example of the work grantees is doing comes out of Michigan. Michigan funded a suicide prevention media campaign focused on a particular group of men that showed with statistical significance that those exposed to the campaign were more likely to seek care. Likely in April 2024, the White House's new National Strategy for Suicide Prevention will be released. This is co-led by CDC and SAMHSA and involves all agencies. This is a 10-year strategy with a 3-year action plan. For the first time, all federal departments (agricultural, labor, et cetera) are committing to actions around suicide prevention.

[3] https://www.hawaiiopioid.org/wp-content/uploads/2019/08/2018-evidence-based-strategies.pdf

[4] https://www.cdc.gov/suicide/pdf/preventionresource.pdf

While ACEs does not have the same immediate feel of counting the number of those dying every year, this is an important issue in terms of a prevention lens and OD2A. The ACEs data are remarkable and show that if the work is done to prevent ACEs and promote positive childhood experiences (PCEs) to balance out the ACEs, there likely would be major impacts on adults in terms of chronic physical health conditions, substance use, depression, et cetera. An analysis showed that if a certain number of ACEs were eliminated, 44% fewer adults would be diagnosed with depression. In thinking about the inability to treat the way out of the mental health crisis, the prevention piece is critical. Nearly 2 in 3 adults have experienced at least 1 ACE. ACEs Funding for FY23 is approximately $6 million, which is much less than the $280 million for overdose. There are 12 recipients of this funding, including states, hospital systems, et cetera that are working on data and driving it to action and there is a new "Adverse Childhood Experiences Prevention: Resources for Action" publication.[5] In an example from Georgia, the recipient assessed regional-level ACEs data and used that to drive interventions for early childhood home visiting in the parts of the state that had the biggest gaps.

In closing, Dr. Arwady expressed her hope that this provided the ACD with a sense of how NCIPC is attempting to tie in the work and the funding to turning data into action and telling the story of prevention. Suicide, overdose, and ACEs are relatable, related, preventable, have a huge amount of impact, and link into the mental health crisis. In terms of talking about the mental health work more explicitly, she expressed interest in hearing from the ACD about how to frame that, how to make sure they are doing a good job of differentiating CDC's role, and about the ACEs framing overall in terms of how central this should be as they are prioritizing this work.

Discussion Summary

Dr. Gayle said that it makes sense why CDC should have a focus on these areas, but she is not sure that people understand that in the broader world. She asked Dr. Arwady how that is being received and how CDC is thinking about differentiating itself from SAMHSA, Health Resources & Services Administration (HRSA), and others who are involved in mental health and overdoes and being clear about that.

Dr. Arwady said she wanted to be careful that they do not always define CDC's role as what they are not, because that already is starting on a "bad foot." There are examples from throughout the country in the overdose space, which has had more funding and more ability to think about implementing things in a broader way, building the evidence base broadly around what prevention and harm reduction look like, and how that applies to other areas. She had a call with a Legislator in Washington who immediately started talking about ACEs with her, which pleasantly surprised her. It always is difficult to show the evidence for prevention. CDC has economists and big data folks who are thinking about how to tell that story better. Even across CDC, there is not always as much recognition that prevention strategies that have worked in the infection space can be applied elsewhere to think about care cascades, where people are falling off, and having standardization. All of this helps fit the non-infectious spaces into a place where people do understand public health's role a little better.

Dr. Gayle said she thinks this is an area in which being able to work with other disciplines more broadly also will help to elevate CDC's role in this by showing the interdisciplinary/intersectoral lens as well.

Dr. Houry agreed and added that CDC worked closely with public safety in terms of overdose work, partnering through some of the drug control strategies. It is about showing what they are doing versus what they are not doing, as Dr. Arwady said. These are all relatively young programs. Dr. Houry made suicide and ACEs priorities when she was at the Injury Center, for which there were no budget lines. Overdose has only been a budget line since 2015. With suicide, they have focused on more of a community-level approach versus individual level. This has helped with differentiation. The more they can talk about how they are using data in innovative ways; people always understand that CDC is the data source; however, she does not want people to think that all CDC

[5] https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf

does is data. That is why she thinks it is always important to say, “data to action.” With drug overdose, they have done a lot with checking syringes to determine what substances are in them. With xylazine coming out, they were able to conduct clinician calls on it. With suicide, there was something called the “Blue Whale Game” in which youth were dying. They were able to focus on that to provide strategies for what to do.

Dr. Gayle pointed out that this is an area in which there is much to learn from global experience.

Dr. Martinez said this is very exciting to him as a psychiatrist and someone who is running a foundation for mental health. The entire country has been experiencing a mental health crisis for quite a while, which is accelerating. Addressing ACEs fits in logically and represents upstream prevention. The US healthcare system tends to fragment and silo itself. Whatever CDC can do to break the silos to think about the data and impact that data can have will be helpful, with the understanding of why this is related to what CDC is proposing. In terms of ACEs and prevention, there already are tools that can be utilized like the Social Vulnerability Index (SVI) and the Area Deprivation Index (ADI). Those can be overlaid to reflect suicides, mental health crises, overrun institutions of health and public health, et cetera. Economics also are important. In terms of how the issues are not being addressed economically, CDC should work with the Federal Reserve, which has some wonderful reports on the ADI. There is despair and death in this country that are impacting communities of color, rural areas, veterans who served their country who are not themselves being served, those who economically are one check away from being homeless, et cetera. The US healthcare system is not a prevention system and often is not even a health system. It is unfortunate that the system is not willing to do more for prevention. CDC needs to help others understand why they need to be at the table, such as Housing and Urban Development (HUD), Department of Education (ED), et cetera. Suicide rates are decreasing in other developed countries compared to the US. Once again, the US is being left behind. Community engagement at the community collaborative level is going to be key.

Dr. Arwady noted that for context, she came from about 10 years at the state and local level. She most recently led the Chicago Department of Public Health. In those spaces, the behavioral health work is much more combined. Mental health, substance use, and violence prevention are on the same team.

Mr. Dawes echoed all of the comments and applauded CDC for prioritizing these issues. In terms of the hierarchy value placed on chronic diseases, it is refreshing to see that CDC is elevating these issues—especially related to suicide. One thing he did not hear with regard to the 49,000 individuals who lose their lives each year to suicide was about 2 other population groups disproportionately represented in these numbers, which include black children and youth and LGBTQ youth. He asked what CDC is doing to address the disproportionality among these 2 population groups in terms of focusing on upstream intervention.

Dr. Arwady said that while she is new to the national space, in Chicago where she came from, they were seeming major increases, particularly in suicide among African American populations. The funded jurisdictions are working to determine which populations are being left out in this work, including the LGBTQ work in the mental health space overall and in terms of suicide. There is overlap with other pieces, including the firearm work. CDC is looking to grow interest and support to make sure that grantees are developing interventions for suicide that are based on the impacted groups and communities with an equity lens.

Dr. Sharfstein recalled that when CDC was concerned that there was over-prescribing of opioids, they wrote overdose best practices prescribing guidelines that were highly influential. When in the past antibiotic overuse was an issue, CDC wrote guidelines on appropriate use. There is an enormous gap in the ability of the medical community to provide effective treatments for addiction. The medical community has owned up to its role in the creation of the opioid epidemic, but perhaps not so much to its role in addressing people with addiction. Many people are not offered effective treatment when hospitalized in the ED despite national guidelines and

legal analyses that suggest they may be violating the Americans with Disabilities Act (ADA). There is still an enormous amount of stigma in medicine that prevents effective and lifesaving care from being offered. Perhaps CDC could create a set of expectations for the medical community that would be helpful.

Dr. Arwady agreed that there is a gap between the need and people getting connected to evidence-based care. With the OD2A funding, they have seen some interventions go statewide, like the ability to get same-day connection to buprenorphine and a care coordinator who can ensure that the pharmacy will deliver that to someone's home so they can get the prescription for the first 2 weeks. There are not enough providers. In the earlier stages, health departments were funding a lot of X Waivers and providing education, but there is a long way to go. Even though SAMHSA not CDC is funding the treatment, there is space around being linked to and retained in care where public health can step in to lead.

Dr. Sharfstein clarified that he was saying something a little different. CDC uniquely has spoken to the medical community about what it needs to do to rise to challenges like this, such as the agency did with regard to opioid prescribing. The same needs to be done at the medical community level, which nobody has done but that CDC could. The medical community should be expected to do for addiction what it does for other chronic conditions like diabetes. In the past, CDC has been very influential at that level. CDC is uniquely positioned to talk not only to the addiction specialty community, but also to medicine about what the expectations are for a situation that is killing 112, 000 Americans annually. This is a moment during which there is plenty of fertile ground. The American College of Emergency Physicians (ACEP) has a practice guideline that often is not followed. The Department of Justice (DOJ) is starting to sue jails for not providing treatment. His school funded an analysis that suggested hospitals should be sued for not providing effective treatment that can reduce deaths by 75%. There is no engagement with the medical community at a high level to set expectations in addition to funding projects that may be good in different areas.

Dr. Arwady thought this felt like something that potentially could be a joint CDC and SAMHSA project.

Dr. Houry added that she plans to connect Dr. Arwady with Dr. Olson at SAMHSA. As they are working with other federal agencies, she and Dr. Arwady are doing some meet-and-greets with NIH and other groups. They can add this to their list. She gave Dr. Arwady huge kudos because she has been in this role for 1 month and had big shoes to fill when Chris Jones left.

Dr. Martinez wondered how far upstream CDC is willing to go in terms of prevention, which means addressing the impact of structural racism.

Dr. Arwady acknowledged that this is central to this work. Depending upon the audience, they might use different words and frame things in different ways, but if they are not talking about structural racism and equity, it is not being true to the work of the Injury Center. She is coming from deep blue Chicago where this was an easy conversation and an obvious link and making that transition in her own mind and with her team about how to keep this central. For these issues in particular, this is critical. NCIPC will make sure that structural racism and equity remain part of its messaging, work, funding, and patterns while ensuring that the work remains relevant to folks from across the political spectrum. That is her opinion and is something she knows her team feels strongly about and will be working on.

Dr. Fleming encouraged NCIPC to engage with its other fellow centers, institutes, and offices (CIOs) directors so that CDC can have a unified voice on issues such as structural racism.

CFA: Progress to Date and Future Initiatives

Dylan George, PhD (Director, Center for Forecasting and Outbreak Analytics) reminded everyone that CFA is one of the newest centers at the CDC and is in the early stages of building out tools, teams, processes, and partnerships. In 2023, CFA developed its 5-year strategic plan that outlines the CFA's long-term mission, vision, and goals. The vision is to empower people to save lives and protect communities from health threats. The mission is to harness cutting-edge analytics to improve response capabilities for public health emergencies. CFA was born out of the pandemic and an explicit recognition that data and analytics need to be used much more effectively to generate the evidence base to keep Americans safe in a time of crisis. In its second year of operations, the CFA already has made significant progress in driving technological and analytical innovations. CFA is trying to create a future in which infectious disease forecasting is as common as weather forecasting is today. From responding to outbreaks with actual data to creating an industry-leading disease forecasting modeling for influenza and COVID-19, CFA is building national capability to use advanced analytics in a time of crisis.

To fulfill its mission and become the trusted source of outbreak forecasting and analytics, CFA needs more than cutting-edge tools and technology. They need good people and sustained support. CFA started in November 2021. At its inception, CFA represented a critical investment in the national public health and national security infrastructure. As they continue to grow a world class organization, it is critical to maintain sustained funding to support its innovative work. CFA started out with multi-year funding in the first year. This was supplemental funding of $200 million from the American Rescue Plan (ARP). Congress then established, authorized, and appropriated a budget line for CFA in 2023 with $50 million. About this time last year, the President requested $100 million for CFA's base funding in appropriations. This is the level of funding that CFA anticipates will be needed to sustain its capabilities. CFA is working to attract and retain an ambitiously technically excellent, creative, and diverse workforce. He often refers to the team at CFA as "crazy good." They are amazing. CFA has attracted people from industry who have left higher paying jobs to work with CFA because they believe in the mission. They have people who have left tenure track positions or foregone tenure track positions who would have gotten extremely good academic positions. It is a "crazy good team" and he is proud to be associated with them. When CFA was launched in 2021, it had just 5 people. About 6 months later, there were 8 people. At 1 year, there were 25 people. There are now 70 people, which is halfway to where they need to be in order to be fully operational.

CFA's 2023 work can be summed up as having used better data to create better analytical tools and focused on collaboration to amplify the center's impact. Better models and forecasts start with better data. CFA relies on high quality data from the DMI and the Public Health Data Strategy (PHDS), and it is critical to build on those efforts and successes. Incorporating these new sources of data in the last year has improved the models so that the CFA can make more robust predictions about disease outbreaks that CDC could not do before the CFA existed. An example of this is wastewater data, which is a new and transformative data that is very exciting within the CFA and within public health generally. There is a lot of excitement about wastewater data, which is reaching the height of anticipation, will hit the trough of disillusionment, and hopefully will get to the plateau of performance. Through the ongoing collaboration with CFA's colleagues in the National Center for Immunization and Respiratory Diseases (NCIRD), the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), and the Global Health Center (GHC), wastewater and syndromic data have been used to develop state-level forecasts for COVID-19. They have found that by layering in wastewater data, the forecasts are more accurate. This makes complete sense because it is a leading indicator of what is going on with circulation in the community, and it helps identify when there are going to be peaks or troughs going forward. This has been a major advancement that would not have happened as fast if not for CFA. CFA also is making advances in how data are used to improve forecasting capabilities broadly. CFA has refactored the code that was used for COVID forecasting by the Response Team, making it much more robust, portable, reproducible, and efficient. The models that are used for COVID-19 forecasting run 10 times faster and with better data processing, so partners

can respond to future outbreaks more quickly and more efficiently. These new data sources, processing techniques, and methodologies solve key problems in understanding what is occurring in hospital systems. Better data leads to faster and more accurate models, which leads to better information that people can use to keep themselves, their families, and their communities safe.

To translate these complex forecasting models for analytics for decision-makers across the nation, CFA has created new decision support tools for the state and local levels. In 2023, the CFA released the first *Respiratory Disease Season Outlook*,[6] providing timely information to decision-makers on how to prepare for the fall respiratory season. The outlook was based on Scenario Modeling Hub data results for COVID-19, influenza, and RSV and predicted that there would be a similar number of total hospitalizations in 2023 compared to 2022. CFA shared this outlook broadly through the website, media, and news outlets. Dr. Adrienne Keen from the CFA team did a brilliant job of making sure that CFA was connecting closely with STLT partners to ensure that they understood what it meant and how to use it. This has equipped STLTs with the knowledge to know what to expect in the upcoming year and to have targeted conversations with their hospital systems to know if they were ready or not.

FluSight influenza modeling is another advance. In November 2023, CFA began submitting weekly forecasts to the CDC FluSight Influenza Forecasting Challenge. This was the first time CDC authored and publicly released forecasting results. The forecasting results previously shown on the CDC website were submitted to CDC by academics or private partners. This is a major milestone and step forward in driving CDC's capability. Dr. Jason Asher from the CFA team has done a brilliant job of galvanizing how CDC advances in that space. In terms of ongoing outbreak monitoring, CFA has had to "build the plane while flying it" and "chew gum and walk at the same time." Regardless of the analogy, CFA had to do multiple things at the same time. CFA has been able to assist with response capabilities for a range of outbreaks, including Mpox, Marburg, Ebola, cholera, COVID, and a handful of others. CFA's ongoing work in developing and sharing better analytical tools has given decision-makers more timely and actionable information during response times.

As CFA continues to grow as an organization, they are building partnerships across sectors to help develop, test, implement, and share data models, forecasts, and analytics. CFA has combined forces with colleagues in NCIRD to co-lead CDC's 2023 Respiratory Virus Response Modeling Task Force. Within the Incident Management (IM), CFA was helping lead that work to make sure that no one had to "beg, borrow, and steal" across the centers anymore. In terms of global collaboration, CFA fostered international partnerships to develop a new risk assessment tool working with the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC), the Pan American Health Organization (PAHO), the Public Health Agency of Canada (PHAC), and the United Kingdom Health Security Agency (UKHSA) to galvanize and generate better risk assessment strategies and tools going forward. The reason they were doing this was because helping to develop these strategies and tools will enable CDC to talk with state and local health departments, discuss the potential risks, and galvanize a better approach going forward.

In terms of a couple of key things that CFA has done, the effective reproductive number (R_t) is an estimate of growth of a particular outbreak or how many infectious individuals will be generated from 1 infectious person. R_t is a measure of how disease spreads efficiently within a community. One of the things that has been very exciting about what CFA has been doing recently is that they celebrated another first in December 2023 upon releasing the first public COVID-19 and Influenza Growth Estimates for every state. The R_t had been publicly released on the CFA website in user-friendly, color-coded, national maps that are updated on a weekly basis. One thing that has been useful about this is that when Dr. George was talking with members of his own family, he could point them to maps of the circulation of COVID and influenza in their particular location and to what they could anticipate in the next days to weeks in terms of a growth or decline in COVID or influenza in their

[6] https://www.cdc.gov/forecast-outbreak-analytics/about/season-outlook.html#print

area. That helped them understand the risk that they would be confronting and assess the level of behavior they might want to change going forward. He is confident that as this is progressively made available and understood, it will be a tool for many more families across the US.

To speed up innovation and progress on new tools for state and local public health, CFA launched Insight Net. This is the first national outbreak analytics and disease modelling network. Insight Net represents the largest government investment in modelling public health infrastructure to date. The 13 performers and awardees represent public, private, and academic sectors. They are categorized into three big groups. The first group is comprised of "innovators" who are developing new analytics and models and testing out new data. The second group is comprised of the "integrators" who are the ones working with health departments to validate that the new analytics are fit for purpose and are going to help analyze or make decisions bigger, faster, and stronger in some way. The third group is comprised of the "implementers" because there are only 13 awardees. It is not a "chicken in every pot" kind of model. In order to figure out how to make these capabilities much more accessible, usable, and understood by as many jurisdictions as possible, the implementors are the ones that are tasked with scaling those capabilities. Coming up with new innovations, testing them with health departments, and scaling them across jurisdictions is what CFA is trying to accomplish with Insight Net. This is a huge step forward in making sure that CDC is working closely with state and local partners to build capabilities at that level going forward because in the federalism system, that is where a lot of decisions and authorities lie.

CFA has a number of goals in the areas of using even better data, creating better tools, and expanding access and availability to STLT partners. In terms of better data, CFA will continue to use new data to improve accuracy and speed and will continue to improve wastewater data capabilities. CFA also is looking at syndromic data, ED visits, and ADT data [HL(2]to help improve the forecast and anticipate how hospital systems are working. In terms of better tools, Insight Net is going to be a key part of the goal to advance the system, tools, and products. CFA will continue to get primary awardees stood up, working effectively as a network of networks and working closely with other Centers of Excellence across CDC. By focusing on rapid innovation, implementation, and systems integration, CFA will empower CDC and its collaborators to develop cutting-edge analytics effectively and to deploy them in the most effective way. In 2024, one of the top priorities is going to be working very closely with STLT groups to make much more progress in that space. This includes enabling new modelling toolkits designed specifically for state and local jurisdictions. They also want to expand access to the advanced cloud-enabled Virtual Analyst Platform (VAP) that will allow modelers at local, national, and even international levels to work in a collaborative way together. This will allow CFA to collaborate, model, file, and co-chair in a much more rapid fashion—especially during an outbreak.

By continuing to invest in methods, tools, and partnerships, CFA is ushering in a new era of data-driven decision-making in a time of crisis. They will continue to work toward a future in which modelling, forecasting, and advanced analytical tools are at the ready for decision-makers and for all Americans. CFA wants to make this a reality going forward. Dr. George noted that he left the private sector to come to CDC because he believes that this is a transformative moment in history. There is a clear need to use data more effectively. There are advanced technologies that can be employed within public health that are being used broadly and effectively in the private sector. There also is a need to make sure that what happened during the pandemic does not happen again.

Discussion Summary

Dr. Taylor said it seems like CFA is building something that is not disease-specific, which has been a challenge for CDC. This is a transformative time in using new technology. It also is a transformative time in diagnostics. The public now has an expectation of home use. The trouble is that the home tests are not delivering data. She asked how manufacturers could be incentivized to develop a system that is non-identifying other than positive

or negative to show whether something is going on, and perhaps use that in combination with data from pharmacies in terms of products coming off of the shelf.

Dr. George pointed out that healthcare moving from the hospital to the home was a long-term trend that was just accelerated by the pandemic. His general practitioner (GP) retired at the end of the pandemic, so he found a new GP who was fully telehealth. Though it was exciting to see, he wondered how long it would work. The box of electronic goodies the new GP sent him to be able to do sensors was inspiring. He completely agreed that home diagnostics, wearables, and biosensors are going to be proliferating over the next 5 to 10 years and is going to fragment the system even more. Trying to aggregate the data going forward is going to create a very challenging environment in which to work.

Dr. Taylor suggested that perhaps this could be done in stages so that people get comfortable with one level of information and then have the next conversation. A huge amount of data will be missing if something is not done.

Dr. Morita recognized what an amazing amount of progress the CFA has made in a very short time. In terms of staffing, they have heard from others in CDC that they have been unable to recruit and hire staff from industry and academics due to not being able to provide higher salaries. She was curious to know why Dr. George thought CFA has been successful where others have not and thought that perhaps others could benefit from this if anything is replicable about it. It also will be interesting to see the extent of retention over time after the novelty wears off.

Dr. George said he thought that the mission of CFA resonated with the handful of people who are working in tech-related spaces. In addition, there has been 20 to 25 years of work in this space of trying to use analytics, modeling, and different sorts of algorithmic approaches that the CFA is benefiting from going forward. One thing that helped was that people were seeing how serious they were about building this organization. Some people are attracted to building a new organization. Once they got the initial nucleus, they began to see a snowball effect. In addition, Congress gave CFA the authority to engage in direct hire. That was a huge benefit because they directly hired 10 people once Congress granted that authority. Having the ability to hire remotely enables them to hire quality people who are struggling with the 2-body problem in an academic sense.

Dr. Morita observed that direct hiring authority and the ability to hire remotely potentially could be replicable. She noted that she is on the Data and Surveillance Workgroup (DSW) and part of the Terms of Reference (TOR) are very specific about the DSW helping inform data modernization as CDC is trying to streamline data sources. Part of the goal is to streamline and simplify but Dr. George was talking about adding new and novel data sources. She wondered how he was thinking about that moving forward. Dr. Cohen has described the need to support the systems that benefit the entire agency and the nation, and not just continuing to do things because that is the way it always has been done. She was curious to know how CFA is engaging with the DMI to ensure that to make sure that additional things are not being added.

Dr. George indicated that he and Dr. Layden talk multiple times a day and work very closely with the Office of Public Health Data, Surveillance, and Technology (OPHDST) team to ensure that they are coordinated and connected. What is going to enable CFA to be successful is the degree to which they can work effectively with state and local jurisdictions and provide them with tools that are successful. Also, the PHDS has to succeed for the CFA to succeed. He also thinks over the next 5 to 10 years there will be a much more fragmented data system within healthcare. There was a glimmer of hope with Apple and Google working on exposure notification, there was huge success in that Apple and Google created infrastructure at the enterprise level to make that possible. A way is needed to aggregate at a level not seen before, which goes against business models and trying to modify data in different capacities.

Dr. Gayle asked how CFA is thinking about working with the private sector and what would help to build those kinds of partnerships.

Dr. George emphasized that he was recruited out of the private sector to help build this organization. The Chief Technology Officer, Eric Rescorla, was the Chief Technology Officer for Mozilla. He agrees that they need to think about how to use different mechanisms to pull in private sector capabilities beyond just the standard contractors going forward. They have been assessing various authorities that they might be able to use, as well as mechanisms such as the Small Business Innovation Research (SBIR) program.

Dr. Gayle said she was thinking less about the development of technology and more about how to harness some of the things they had been talking about, such as thinking upfront about how to reduce fragmentation. Perhaps a broader strategy needs to be put in place at a higher government level, perhaps even the departmental level, to think about making explicit agreements. This is incredibly inspiring. Part of what the ACD is interested in is about how to continue to build CDC's credibility. This offers a lot of credibility to CDC after a time when people thought the agency did not have that type of capability. In terms of communications strategies, she asked how they will disseminate and leverage this information beyond STLT health authorities and the impact that it is going to have on disease prevention to thinking about building trust in public health science.

Dr. George said that at the beginning of the pandemic, he was working in the private sector. They had many conversations with Apple, Google, and a handful of other groups that were trying to build the infrastructure that would allow people to do things for exposure notification. More needs to be done in this space. He agreed about the need to leverage this work to build credibility. He previously worked at the White House in the Office of Science and Technology Policy (OSTP) where they were thinking a lot about how to develop this capability. Dr. Louis Uccellini, the Director of the National Weather Service (NWS) at the time, told him a great story about how they had these beautiful models for tornados and other severe weather, but they had terrible ways of communicating the modeling results to the point that some of their risk communications were putting people in harm's way during tornados. The message that Dr. Uccellini was trying to teach him was that one can have the best model in the world that will indicate exactly what is going to happen, but if it is not communicated in a way that people understand it such that it elicits the behavior that will protect them, it does not matter how good the model is. That is one of the reasons that CFA has spent at least a third of its effort trying to figure out how to communicate results more effectively.

Dr. Medows noted that another part of the healthcare industry are healthcare providers and healthcare payers. She stressed the importance of talking to them and bringing in some of the early adopters, otherwise all of the work the CFA is able to do may not translate into a clinician or health benefits program being able to address what is in the data. At some point there must be a bridge and they must not lose their focus. Health plans have data that will provide sentinel information, particularly pharmacy data, antivirals use, et cetera.

Dr. George highlighted that over the last 2 years, CFA has been working with the University of Utah, University of Utah Hospital, and Intermountain West Hospital. One thing that was very exciting about what they developed was that during the pandemic, they were able to use their electronic health records (EHRs) to get situation awareness of what was happening in the hospitals. They were working with the university to generate forecasts based on those data to understand what would be happening over the next handful of weeks in the hospital. They used those data to figure out absenteeism of clinical staff, how much they would have to back fill, and how many heads in beds they were going to have from COVID. That helped determine how many elective procedures they could do as well. They also used the data for scarce resource allocation for Paxlovid™ and vaccine in the early part of the pandemic. This is an early example of how they were trying to work with healthcare to make

granular decisions. They are one of the awardees in the network, so the CFA is working with them to see if they can scale that. They are open to any feedback about how they might scale that more effectively.

Dr. Taylor pointed out that there is a communication issue and a manufacturer incentive issue.

Dr. George recognized that the diagnostics model and business model are challenging from the standpoint of return on investment (ROI), which is not what it is for therapeutics or vaccines.

Moving Forward Initiative Update

Kate Wolff, MPA (Chief of Staff, CDC) presented an update on the Moving Forward Initiative. She noted that one of the key roles she was charged with when she started a year ago was the continued implementation of CDC Moving Forward and the tremendous effort that started over the Summer and Fall of 2022. CDC Moving Forward is an effort to promote a public health action-oriented CDC committed to accountability, collaboration, communication, timeliness, and equity through refining and modernizing CDC structures, systems, and processes. Part of that work involved creating priority action teams that were comprised of staff from throughout the agency who put forward recommendations on discreet actions for CDC to take and implement over the course of a couple of years. Currently, the agency is in the middle of that implementation process. As a reminder, the 7 main core areas for improvement within Moving Forward are to:

- ❑ Share Scientific Findings and Data Faster
- ❑ Increase Laboratory Capacity, Quality, and Safety
- ❑ Translate Science into Practical, Easy to Understand Policy
- ❑ Prioritize Public Health Communication
- ❑ Develop a Workforce Prepared for Future Emergencies
- ❑ Promote Results-Based Partnerships
- ❑ Modernize Data
- ❑ Integrate Health Equity (called out on its own and embedded across all areas)

The recommendations ended up with about 160 discreet actions that were distributed into each of these areas. Some of the actions were one-and-done, such as changes to a specific policy or making sure the right communications people were involved in the right response activities. Other actions require ongoing implementation efforts, which are being monitored. At this point, more than 75% of these actions have been completed. The remaining 25% are on track to be completed over the course of the next year. The next chapter of Moving Forward is to build a strong foundational base of operational excellence across CDC that will help the agency succeed in the priority areas that have been identified. Another element of Moving Forward was some of the reorganization work that happened a year ago in which offices were elevated and more cross-cutting work was done to try to break down some silos across centers.

To share some of the highlights of the work to illustrate where Moving Forward has demonstrated added value to the work being done across the agency, scientific findings and data are being shared faster. Changes to improve the efficiency and effectiveness of the current clearance system have cut review times in half, resulting in a 120% CDC-wide improvement in the clearance rate. Another illustration of sharing scientific findings and data faster is the respiratory virus response this Fall when weekly updates were posted on the CDC website to convey what was known about the latest variant or updates about vaccination. CDC is trying to use all of the tools available to them to communicate the science that they have. Ms. Wolff recognized and thanked the ACD for their close involvement in the work pertaining to improving laboratory capacity, quality, and safety. The ACD's recommendations were rolled into the Moving Forward work as actions in this core area. While there are some ongoing actions in this area that still need to be implemented, one item that has been implemented is the

Electronic Quality Management System (eQMS) that is part of the broader laboratory quality plan. This is currently being piloted for a phased rollout across the agency in 2024.

In the area of translating science into practical policy and implementable, understandable, and meaningful public health guidance, the Public Health Guidance Framework (PHGF) is being applied and working well in many of CDC's areas. In terms of prioritizing public health communication, Clean Slate is an initiative to re-envision the CDC.gov website with optimized, streamlined content. This website has hundreds of thousands of webpages and they have been working hard to go through every single one of those pages to make sure that the information that is available to the public is useful, meaningful, and appropriate for that audience. The website will be relaunched in the Spring. The expectation is that there will be a reduction of at least 64% of the current content as part of this process. So as not to raise any alarms, everything is being archived. The workforce piece of Moving Forward is a critical component. Internally, CDCReady has been launched, which is a platform that the agency is using to organize itself for a response. Every single person at CDC is able to create a profile within the CDCReady system so that when there is a response for which staff need to be deployed, it will be possible to find the right expertise and skills from the right places to help put them at the forefront of the response. This platform also allows those who are participating in the response to have easy access to the data, reports, and everything that has come before. This reduces the administrative burden of joining a response.

In terms of integrating heath equity, the PHIG is one way in which CDC is working to build the public health system that is needed across the country, not just at CDC, and making sure that the agency's grant programs are aligned not only with the workforce needs internally, but also the goals pertaining to equity in the workforce. Modernizing data is a huge part of the Moving Forward initiative. Regarding CDC's electronic case reporting (eCR) work is underway to improve that effort. More than 28,000 facilities across all states are using eCR, which increases data efficiency and provides real-time case reports for disease tracking, case management, and contact tracing. Improvements have been made, such as the wastewater visualization and dashboard in an effort to harvest the data CDC has to make sure it is getting out quickly to those who need it in a usable format. Another major component of Moving Forward is promotion of results-based partnerships across the agency. The best example for this is using Collaborative Initiatives. Projects have been identified for this domain in 3 areas that are targeted at results-based partnerships, which include: 1) rapidly identifying and responding to threats; 2) improving mental health and combatting the overdose crisis; and 3) supporting young families. These areas are targeted at results-based partnerships in terms of how CDC is bringing its expertise and resources to the table in these areas, measuring success, and implementing what has been learned. CDC is excited about this next phase of Moving Forward to demonstrate how partnerships are essential to all of the work done by the agency.

In terms of the Moving Forward timeline, the agency is squarely in the implementation phase and is tracking and monitoring the use of new processes that have been put in place, and thinking through how to build on the successes of Moving Forward to make the One CDC enterprise-wide foundation as strong as it can so that whatever the challenge is, CDC has a strong base from which to launch. The biggest challenge is that some of this work requires massive shifts in the way that the agency works together. While these discreet actions are important and needed to happen, they cannot "take their foot off of the gas" and must continue to demonstrate how these changes are a value add in helping the agency move forward.

Discussion Summary

Dr. Sharfstein emphasized how fantastic the Moving Forward work is. It is very difficult to execute internal projects like this when there are so many demands from the outside world occurring simultaneously. It is incredibly important to fix things that have been problematic before while setting a strong platform from which to do many things in the future.

Dr. Taylor noted that one thing the Laboratory Workgroup (LW) raised was the structure of the Incident Management System (IMS) structure in emergencies, which did not seem smooth at best during COVID. Now that the agency is working toward One CDC, she wondered how the IMS would be structured.

Ms. Wolff responded that CDC is actively looking at this now related to the Graduated Response Framework (GRF) because in some ways, it boxes them in when it gets implemented. CDC came out of the Public Health Emergency (PHE) last spring. Entering the Fall and Winter respiratory season, they were thinking about how to organize the agency when not in an emergency, but there is an issue that requires all-hands-on deck across agency systems. What happened, that worked well, was that NCIRD set up a Respiratory Virus Response Group that included all of CDC's enterprise-wide functions. Everyone was excited to sit at that table and participate. This group met regularly, though without as much of a formal structure as an IMS. That worked well, with the exception of the fact that when the word "response" is included in anything, people feel a certain way about it and behave in a certain way. This will have to be worked through going forward, but this was not technically an emergency. That was somewhat of a new feeling for folks, but a lot of good lessons were learned. That said, they are trying to think through the GRF to figure out how to make that fit and are similarly thinking about the next Mpox response. What is the right way to make sure that the agency is organized, prepared, and leaning in so that they are ready should they need to go into an emergency phase in a way that not everybody is constantly in an emergency response. It is a tough balance.

Dr. Houry added that they are trying to get past the word "response" because they have heard from some of the staff that they get Post Traumatic Stress Disorder talking about response. The intent is to routinize it and have people prepared so that people have awareness that it is more programmatic in nature where possible.

Dr. Taylor said the other important thing is that people at the executive level of the IMS need to know everything. There is an expectation that some things will go wrong, but they need to know about it in order to do something about it. People take pride in their work and do not want to admit that there is a problem.

Dr. Morita said that when she heard the term One CDC, to her it was about breaking down the silos at baseline—not just during a crisis. In terms of the mental health work, the goals were clearly defined in terms of the agency-wide priorities and NCIPC's priorities. Having a responsible person can help break down some of the siloing that occurs.

Ms. Wolff said that Dr. Cohen was very clear on her first day that she saw the direction of Moving Forward and wanted to make sure that continued under her watch. It is clear to see how Moving Forward has evolved in a healthy and productive way. It is true that CDC staff cannot just work together in a crisis. An example of a way that is being executed for readiness and response is that there is a leadership meeting in the afternoon that every CIO Director or their Deputy is invited to attend. Everybody is at the table, which has to do with visibility and transparency in that area. Dr. Cohen's thinking about the priority areas is that everybody should be read-in, know where they are going, and potentially can be tasked with a role in that area as needed and appropriate. This is set up for all of the priority areas. This is even more granular in the collaborative initiative pieces when people outside of CDC are brought in.

Dr. Fleming pointed out that these things work best, and perhaps only, if there are dedicated staff beyond CIO Directors or Deputies who show up who can serve as the nidus for the momentum to continue.

Ms. Wolff said that this is another area for which Dr. Walensky was able to find resources when this project was kicked off. Aside from this being part of her performance plan, Ms. Wolff is accountable for staff who help with various pieces of this.

Dr. Fleming highlighted some areas with regard to the results-based partnerships, health equity, equity, and climate. Even the ACD's recommendations for equity suggested that CDC needs to engage with partnerships beyond HHS with other health agencies, which is certainly true for climate as well. He asked about the extent to which CDC is able to find the resources to engage with HUD, the Department of Transportation (DOT), the US Department of Agriculture (USDA), and the other non-HHS agencies that are critical for CDC's success in those areas.

Ms. Wolff said that there are some places with which CDC has a head start more than others. During COVID especially, there were a lot of inter-agency engagements because CDC had an impact across agencies. There were good connections built. Many CIOs are engaged with the USDA and there certainly is an opportunity at a leadership level to deepen that work. The food work is happening in one place and animal health in another, and there is One Health work as well. CDC's relationships with the Department of Education partners grew with COVID, so they have talked with those partners about some of the school-based mental health work that is happening. There are many other school-based public health issues for which CDC has good connections with the Department of Education. There are opportunities in terms of climate health to work with National Oceanic and Atmospheric Administration (NOAA) partners. In terms of behavioral health, there is more work to do within HHS as well. In terms of the intersection between public health and healthcare, there are ideas for ways in which CDC can better connect with CMS colleagues.

Dr. Taylor emphasized the importance of CDC advertising what it is doing. A *Scientific American* article was published on CDC's good progress, but the agency needs to tell the world about all of this progress.

Health Equity Update

Leandris Liburd, PhD, MPH, MA (Acting Director, Office of Health Equity, CDC) first acknowledged the ACD for their leadership and contributions in laying out recommendations to enhance and accelerate CDC's efforts to achieve health equity across its broad portfolio of public health science and programs. For new members, she provided a quick summary of the process. The now-sunset Health Equity Workgroup (HEW) of the ACD put forth action items across 3 task areas, which were then adopted as recommendations by the ACD and subsequently acknowledged by the Secretary of the Department of HHS. The OHE was then tasked with leading the implementation of the recommendations in close collaboration with the national CIOs of CDC. During the last ACD meeting in November, Dr. Liburd provided a brief overview of CORE, which is CDC's Health Equity Science and Intervention Strategy, and also described some actions that were underway to incorporate the ACD's recommendations into CDC science, programs, and policies. During this session, she discussed the OHE's continued progress and accomplishments and reflected on the work that remains.

The OHE was launched in 2023. It builds upon the agency's 35 years of focus on racial and ethnic minority health. The OHE exists to ensure that health equity is embedded in an all-of-public health approach to overcoming persistent health disparities and health inequities across a range of population groups that disproportionately experience poor health outcomes. This work is done in collaboration with the national CIOs across the agency. In standing up the OHE over the last year, they identified 5 strategic imperatives as part of a much broader strategic plan, highlighting priority goals and major activities through the 2024 calendar year. OHE is using this plan to pursue its mission and guide its day-to-day work to advance health equity.

The first imperative is "Strategy." If a commitment to health equity is going to be successful, OHE must institutionalize its principles and practices and align agency-wide initiatives to accelerate progress toward achieving health equity. Toward this end, the OHE developed an office-wide strategic plan that is one of Moving Forward deliverables that the OHE submitted at the end of last year. It also includes a multi-year roadmap and metrics that integrate health equity, social and structural determinants of health (SSDOH) and diversity, equity, inclusion, accessibility, and belonging (DEIAB). This is the foundation for creating long-term change within CDC to advance health equity. Across the additional 4 strategic imperatives focused on Funding, Partnerships, Public Health Workforce, and Science and Interventions, the OHE is operationalizing the recommendations that were approved by the ACD. The OHE has intentionally aligned the activities within these imperatives with the ACD health equity recommendations for which Dr. Liburd highlighted some of the progress.

Consistent with Task Area 1, CDC recognizes community engagement as the cornerstone of good public health practice. The "Partnerships" imperative is focused on increasing community engagement with populations that experience health disparities and health inequities. For more than a decade, the OHE has collaborated with public health organizations such as ASTHO, NACCHO, and more recently the National Association of State Offices of Minority Health (NASOMH) to promote health equity. Last year, the OHE established and convened a collective of public health leaders representing state, local, and territorial departments of public health and established what is now known as the Power of Partnerships Health Equity Alliance (Alliance). This Alliance is a forum for problem-solving and information exchange as they work to integrate and institutionalize health equity into the day-to-day practice of public health. The OHE is continuing to expand its partnerships with STLT organizations through continued collaboration with the CDC's PHIC that is now also a collaborator in the Power of Partnerships Health Equity Alliance. By aligning more closely with PHIC, the OHE seeks to improve and increase community engagement among departments of public health. The OHE also has developed an overarching health equity partnership plan to facilitate the strategic engagement of partners. Since the last ACD meeting in November 2023, the office has convened meetings with multiple organizations that prioritize racial and ethnic minority groups, including the National Medical Association (NMA); the National Hispanic Medical Association (NHMA); the American College of Preventative Medicine (ACPM); a community-based organization (CBO) called Choose Healthy Life (CHL); and another organization called PROCEED that is focused on Hispanic and Latino populations; among others. In these meetings, the OHE has sought to determine how they might be able to collaborate more closely in the future.

In 2023, the OHE launched a series of health equity partnership webinars to bring together an intersectional collective of health equity organizations that focused on a range of populations, including racial and ethnic minority groups, people with disabilities, people who identify as LBGTQ+, and more. Public health, health care, and other partners joined the partnership webinars to learn about and apply promising health equity strategies in their communities—hearing from both CDC and external partner programs. The OHE has organized 2 webinars to date. Over 2,500 partners registered and over 1,300 joined live. One of the ways that the OHE has been supporting the larger efforts of Dr. Cohen's priorities, the OHE reached out to more than 70 CBOs and national minority serving organizations to share with them the respiratory virus season prevention messages and to get feedback on how that could be done even better as an agency. The OHE performed a thematic analysis of the feedback, which the OHE has shared with the NCIRD and they are working to address the challenges and gaps raised to ensure that there are improved, culturally relevant, and informed messaging for priority populations who are disproportionately impacted.

Task Area 2 calls out the impact of CDC's organizational structure and how it affects the staff's ability to pursue health inequities. Because of the tremendous role and responsibility that CDC has in instituting and supporting public health programs, projects and activities, resource allocations, and program guidance, the OHE has a strategic imperative on "Funding" that is focused on ways to expand the integration of health equity in this area. Through CORE over a couple of years, the OHE convened health equity subject matter experts (SMEs) from

across the agency to figure out how to incorporate guidance around health equity in the non-research NOFO template. The OHE is pleased that after that process, they have been able to put forward health equity considerations that will cue the NOFO writers to address health equity in the design of their NOFOs and, after being published for competition, will cue applicants to address health equity in the framing of their programmatic response. The OHE is working closely with the Office of Grant Services (OGS) to launch a training series in Spring 2024 to help socialize the health equity guidance that is now part of the NOFO template. At the beginning of February, CDC posted the full NOFO for the "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health" cooperative agreement, also called the "National Partners CoAg." This cooperative agreement takes the place of CDC's "National Partners Umbrella CoAg", which will be sunset on July 31, 2024. The OHE sees this as an important opportunity for national Minority-Serving Institutions (MSIs) to compete for resources from CDC. In mentioning this new cooperative agreement, the OHE welcomes the ACD's assistance in helping spread the word about the new opportunity. The applications are due on April 1, 2024.

For Task Area 3, the OHE is collaborating with other CIOs to develop approaches and resources to facilitate the systematic and consistent integration of recommended practices for health equity science across the agency. The OHE's "Science and Interventions" imperative underscores the need for equitable community-informed approaches to advance health equity in research, surveillance, evaluation, preparedness and response, and laboratory science. The OHE is working closely with the Office of Science to increase awareness and application of the Health Equity Science Principles that also were published in *Public Health Reports*. The OHE feels very good about the rigor of those principles.

As the agency's health equity champions, the OHE is working collaboratively across CDC to achieve key milestones toward the advancement of health equity. The ACD's health equity recommendations provide a framework for how the OHE may chart additional efforts that would accelerate movement toward health equity. The OHE recognizes that health equity must be at the core of developing any intervention, innovative solution, policy, or programming for populations affected by health disparities, including the authentic representation and inclusion of community members and CBOs. Looking ahead, CDC is taking steps to shift how the agency conducts its public health research, surveillance, and implementation science through innovative collaboration. In addition, the OHE is working to integrate health equity consideration and funding to address drivers of health inequities. The OHE recognizes that they must recruit and retain a workforce that represents diversity and academic disciplines, lived experience, and is prepared to do the work that will reduce and ultimately eliminate health disparities while also ensuring that people have the opportunity to attain their best health possible.

Discussion Summary

Dr. Fleming observed CBOs are important in terms of doing frontline work, particularly in communities of color, but they are often small and poorly funded. As a consequence, they are unable to compete effectively for funding in the current funding environment. Based on how NOFOs are constructed, a solution to that is longer-term. Anything that the OHE could do through TA and/or cooperative agreements to entities that could, in turn, provide sub-grants to smaller CBOs would be a high priority on his list. That was one of the fundamental issues raised in the HEW. They heard earlier that action is driven by data, but one of the problems with health equity measures is that there is no sense of uniformity or commonality across CDC programs and oftentimes focus is more on individual measures of health as opposed to community measures of health. Anything the OHE could do to jumpstart a cross-CIO approach to measures of health equity that is informed by the community and focuses on positive determinants at the community level also would be important.

Dr. Liburd mentioned that the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has a surveillance system called PLACES, which is local data that is comprised largely of social determinants of health (SDOH). The newsletter coming out at the end of the month has an article on PLACES. The OHE is also working with OPHDST and the ORR to create a set of health equity metrics that would be used for readiness and response. There are many conversations underway around data and she is hopeful that they will start to see some implementation of that.

Dr. Fleming said that anything the OHE could do to increase the likelihood that, for example, the NCCDPHP's specific measures become CDC-wide measures or evolve to CDC-wide measures was what he was advocating for because measures that differ across different programs create chaos, inefficiency, and discouragement for those on the frontlines with limited resources trying to figure out what to do.

Dr. Gayle said it is complicated because so many issues regarding health equity go well beyond what CDC is mandated to do, so she was wondering how they were thinking about initiatives across agencies to use a SDOH model, if that is happening, and whether it is feasible. With a focus on communities and given the fact that there is so much pushback around anything that has to do with equity in different states throughout the nation, she wondered whether that was becoming an increasing challenge as well.

Dr. Liburd said that regretfully, the focus of what the OHE is trying to do and the populations that are intended to benefit from them have become politicized. Historically, this is not the first time. There are waves of more and less focus on addressing health disparities and being able to take the courageous steps that are necessary. If she could say there is good news, they have made a lot of progress in terms of knowledge, understanding, and discussions of SDOH. There is much more evidence now. In terms of the actual investment and the resources to address SDOH through systems of public health, she thinks they still have a long way to go. The OHE is trying to do through its partnership focus is to engage traditional partners and move beyond that as well. They are having informal conversations with private entities that have a health disparities agenda in order to think about how to work more closely with them.

Dr. Gayle said she was thinking about the housing and health work that was done in Chicago, which was in different spaces and departments and working across those. She asked whether the OHE is getting any support for those types of initiatives that are partnerships with non-health entities.

Dr. Liburd said that they are not doing so from the OHE's standpoint, but this could be occurring in other parts of the agency.

Dr. Gayle emphasized that this would be important to begin exploring. Seeing a difference in health equity is going to take that kind of cross-departmental, whole of government approach. CDC should be the one to drive that.

Dr. Martinez said he was thinking about what the inflection points might be in organizations that can result in loss of gains made with health equity. One of them has to do with the people. Whenever there is personnel change, especially any positions of authority where there has been a change in leadership, he would recommend that they have to meet with Dr. Liburd and her staff to emphasize how important health equity is to the CDC enterprise. In addition to that, he would recommend elevating and keeping folks accountable. Time tends to soften approaches or other issues start to gain greater priority. Within that context, consideration has to be given to keeping things fresh with regard to health equity. The fact that Dr. Liburd attends the ACD meeting every time is one thing, but it would be helpful for her to identify the metrics that get solidified and create a summary page that she can share with the ACD at a high level so that the ACD can weigh in at a granular level. That also should be shared with Dr. Cohen and all units know that. There has to be an additional

level of accountability when trying to make cultural shifts stick and become embedded across different systems and in an interdisciplinary fashion.

Dr. Medows said she was thinking during the presentation that she hoped Dr. Liburd has at least 6 clones because it has such a wide breadth of things that need to be addressed. The OHE should pick something common that goes across all of the major leadership groups within the organization and tie performance measures to that and accountability. New health equity measures can be developed with the National Quality Forum (NQF) and others. At the same time, CDC already has information about disparities in diabetes, hypertension, heart disease, asthma, colon cancer, prostate cancer, et cetera. They could pick 5 to 10 of those by geography. Everyone at CDC needs to row in the same direction. She recommended that CDC pick something and develop a performance measure that everybody can see and be held accountable, and then they have to report on so that it is visible to Dr. Cohen and the public. She recognized that the OHE is focused on health disparities of populations and DEI simultaneously. Those are 2 massive jobs. While they are both, if she had to pick, she would focus on the populations who are currently suffering and focus on the disease states and conditions that are avoidably causing suffering. They have to pick something concrete, and everybody has to row toward it, and it has to be measured and reported out. Paper is magic and so is electronic data, but it has to be reported out so that people can see it. That is when people feel motivated to move, so even the people who are most skeptical can still see whether movement and progress is being made. This has to involve all sectors of the agency (e.g., IT, finance, contracting, et cetera). Everybody has to be part of the team working on health equity and not just be bystanders, and then health equity performance measures must be built in.

Dr. Liburd shared that the DEIAB team has moved out of the OHE and is now with the Chief Operating Officer (COO) for exactly that reason. The reason DEIAB is important is its contribution to reducing health disparities. Through the CORE initiative, they also have asked the national CIOs to commit to 2 goals that they are going to pursue and drive toward an outcome. This process is underway right now, with 11 centers having done that. There already is a reporting system that goes along with CORE. She will be able to share which metrics they will be collecting from all of the CIOs at the next meeting.

Dr. Morita pointed out there is only so much that can possibly be done. When trying to build an ocean, it becomes virtually impossible. Given that the OHE is a small office with limited resources, one thing to do would be to have the OHE serve as more of a resource to establish best practices and provide frameworks for everyone to use throughout the organization. Throughout the conversations of the day, data consistency and community engagement were lifted up consistently as priority areas. RWJF has some equity competencies that they were using for individual performance management that she would be glad to share with Dr. Liburd.

Dr. Liburd said that over the last 3 to 4 years, the approach has been to focus on creating the standards so that when people ask what health equity is, they can lay that out. They have created training programs and the substance of what it is they want people to do. The next step is socializing that across the agency. There are health equity SMEs in most if not all of the CIOs who probably are doing similar things. Having a single or unified approach is tough, but it is not impossible. In addition, all of this takes way longer than one would imagine. Ultimately, the OHE's goal is to be a resource to the agency. However, they have to define what it is they are being a resource for. Even the laboratories are trying to identify what health equity means for them, so there are dual processes going on throughout the agency. The OHE is providing technical leadership, coordinating, and collaborating, but the CIOs are doing some of their own work along with this.

Communications and Public Engagement Workgroup (CPEW) (Proposed)

Andi Lipstein Fristedt, MPA (Deputy Director for Policy, Communications, and Legislative Affairs) indicated that her role is a newly created leadership role at CDC aimed at providing wholistic, strategic leadership across the agency's communications and policy work streams. She is excited about this opportunity to continue to build

on the efforts to optimize effective communications and to leverage the expertise and experience of the ACD members in thinking about this important work. Prioritizing public health communications by improving how CDC interacts with the public remains central to the Moving Forward work. This is central to CDC being trusted, highly effective, and embedded in the larger integrated system that protects public health. A huge number of deliverables have been driven forward for this work that include efforts such as building a new and easier to navigate website, more real-time communication about health threats, thinking about transparency and what that means, and plain language training for scientists and staff across CDC to name a few. The pandemic laid bare the role of communications in protecting health. Communication is about getting the right information to the right people in the right way at the right time. There are major implications for weather and how people can use that information to protect themselves and their loved ones. The extent to which communication gaps with historically marginalized populations continue to persist is a very important part of this conversation. This has continued to evolve. Communication is a shifting ground not only because of the moment public health is in, but also because of the reality that people are seeking different types of content (e.g., shorter, more accessible, blogs, visuals, et cetera) and are frequenting different communications channels with the proliferation of digital methods of communication. Consideration must be given to what all of that means for the ability to reach the public with the communications that need to reach them to optimize public health. There are new challenges all of the time, including people being inundated with increasing volumes of information (e.g., good information, misinformation, and disinformation) overall.

With all of that in mind, the Communication and Public Engagement Workgroup (CPEW) is being established to assist the ACD in developing recommendations for CDC on agency-wide activities related to how to communicate directly and more effectively with the public, and in particular with a focus reaching local communities with messages that will resonate and will have the desired impact. The CPEW will convene a balanced group of SMEs to assist in the development of advice and recommendations to CDC around effective communication goals. While there are a lot of important dynamics at play here, CDC has identified 5 key goals that are most important at this time, which are to: 1) build relationships and communicate with trusted messengers; 2) improve risk communication practices; 3) delivery action-oriented messaging; 4) tailor messages to audiences; and 5) increase transparency.

Kate Galatas, MPH (Designated Federal Officer [DFO] for CPEW) provided an overview of the proposed composition and charge of the CPEW, the charge for the WG, and the next steps. She began by noting that she has long respected the importance of the contributions that the ACD makes to the CDC. Every discussion of the ACD throughout the day mentioned, touched on, or acknowledged the important role of communications in public health. This is an important charge to take forward. Ms. Galatas started her public health career as a Communications Director in state public health and has worked for 20 plus years at CDC in communications. She was the Acting Communications Director in the early months of 2020 and the last 8 to 9 months of the Trump Administration, which gave her a unique perspective. She saw close up what was working, what was not working, and the impact that the communication challenges had on how nimble and how adaptive CDC's communication strategy could be in the face of what the nation and the world were experiencing.

The full Terms of Reference (TOR) were provided to the ACD members prior to the meeting. The draft name is the Communications & Public Engagement Work Group (CPEW). The CPEW Co-Chairs are Drs. Octavio Martinez and Rhonda Medows. The composition of the CPEW will be up to 15 members with expertise in the following areas:

- Communications, including public relations, health communication, risk communication, communication research, and marketing
- Community and partner engagement
- Public health science and practice, including implementation

- ❑ Behavioral science/behavior change campaigns

In terms of the charge to the CPEW, the following potential areas of exploration have been identified:

- ❑ How can CDC build more robust relationships and mechanisms to communicate via trusted messengers (e.g., clinicians, faith leaders, et cetera)?
- ❑ How can CDC improve and tailor its risk communication efforts to better align with audience perceptions and match risk levels?
- ❑ What are the ways CDC can deliver more actionable, understandable, and focused communications to help people protect their health?
- ❑ How should CDC tailor messages and communications methods to different audiences, particularly for historically marginalized communities?
- ❑ Are there considerations to achieving greater transparency in addition to increasing the pace, content, and reach of CDC's communications?
- ❑ What mechanisms should CDC use to evaluate and measure progress in its public-facing communication efforts?
- ❑ How might CDC ensure greater consistency and minimize perceived contradictions in its communications at all levels?

These questions are not particularly new. These are questions that those in the communications space have asked themselves and have wanted to explore many of these questions for many years. What is unique and exciting now is that there is a shared sense of urgency to get this right. It is difficult to capture how much of a spotlight the pandemic put on the challenges that CDC has faced over the years. Establishing the CPEW offers an important opportunity to have outside voices who are informed and who understand this space to recommend to the ACD ways that CDC can make needed progress in these areas and more.

In terms of next steps, based on the results of the vote, members will need to be recruited. In addition to soliciting input for potential members from the ACD members, CDC will publish a Federal Register Notice (FRN) to invite participants external to the CDC and the ACD to join. A review panel will be set up to help establish the criteria and select the CPEW members. The first CPEW meeting is anticipated to be scheduled before the third quarter of 2024 and a summary report or reports to the ACD by June 2025.

Discussion Summary

Dr. Medows said that one of the things they discussed prior to this meeting was making sure to include preparation for timely addressing of misinformation. It is not only about what needs to be said accurately, clearly, understandably, and taking a consumer approach. They also need to address the misinformation that so easily takes down and destroys the credibility of what they are trying to say. Including a member with expertise in the area of misinformation will be important.

Ms. Galatas pointed out that the field of communications writ large is struggling with that issue and CDC is not unique. She agreed that a member with expertise in that area will be important.

Dr. Martinez said he was honored to serve as Co-Chair along with his colleague Rhonda Medows. They have discussed the multiple levels (e.g., provider, community, systems) and each one of those has sub-categories. The 15 experts brought to the CPEW will provide expertise, insight, and credibility to the WG that will illustrate that they are truly listening to all communities. Misinformation and social media can impact things very quickly and will be top of mind. It is critical to rebuild trust in CDC and trust that inherently exists in relationships that are

respectful of each other. He thought if the CPEW took that perspective, they could make some wonderful recommendations to the CDC to follow through on.

Dr. Medows suggested adding to the Community and Engagement goals "Preparation and planning to effectively and timely address misinformation."

Dr. Morita said she was pleased to see that relationships and trusted messengers were part of the priority areas, especially at a time when CDC has lost the trust of the public, HCP, and others in the nation. Re-establishing that trust may require some help from other trusted messengers. The health department in Chicago was not known as a source of trustworthy information when she was there. Over time, they partnered with the American Academy of Pediatrics (AAP) and other organizations that were trusted resources to help establish the health department's trustworthiness moving forward.

Ms. Galatas agreed, noting that there is a continuum of building, maintaining, losing, and rebuilding trust. In cycling through that, the ability to connect with and have meaningful relationships with a wide set of partners who can help carry the message can be more impactful and meaningful to the communities they serve. That is always a winning approach, especially now when CDC is having to double down on rebuilding trust.

Dr. Sharfstein asked to what extent STLTs are constituents in this effort. STLTs often feel cut out of information. Public health is a team. If CDC is focused on its community partners and its messages to the exclusion of how others in the public world are going to be community, it can be hard to be fully successful.

Ms. Galatas indicated that CDC absolutely wants the perspectives of STLTs represented in the CPEW and the strategies of who CDC is trying to engage.

Dr. Fleming added that many state and local health departments no longer feel that they are in the role of being a trusted messenger. His understanding of one of the keys to effective communication is coherency and consistency across messengers. Figuring out how to make that happen is going to be important.

Dr. Taylor said she often wonders how many people are objecting to the vaccine versus objecting to the mandate. CDC uses risk communication a lot, as if CDC or public health is deciding the risk for a person. However, it may be better to phrase it as the pros and cons and let adults work out their own risks. What is being done now is not working.

Ms. Galatas said it is much less about how CDC thinks about risk and chooses to communicate it. It is all about risk perception. CDC does not always know enough because of the challenges of conducting that type of research in public health, but risk perception drives behaviors. Understanding how audiences perceive these issues and then being able to create solutions, deliver messages, and use communication strategies effectively, it is necessary to start with where audiences are on the spectrum in terms of their perceptions of risk.

Ms. Lipstein Fristedt added that there is not one answer to that depending upon the topic, audience, and moment in time. Part of what the CPEW can assist with is how to think about that in these different contexts.

Vote #1: Establish the CPEW

Dr. Martinez made a motion, Dr. Medows seconded, and the ACD voted unanimously to stand up the CPEW with the TOR as presented.

Closing Remarks / Adjourn

David Fleming, MD (ACD Chair) expressed gratitude to the ACD members for their participation, thoughts, and excellent discussion; Dr. Houry and the wonderful ACD support staff who made this meeting possible through a remarkable amount of work, which he equated to synchronized swimming underwater; and to Dr. Cohen and all of the CDC leadership for their attendance and willingness to engage with the ACD on these important discussions.

Debra Houry, MD, MPH (DFO) echoed her gratitude to everyone and reiterated how delighted they are that Dr. Gayle joined the ACD. They also hope to have additional members onboarded by the next meeting. There is a spotlight on the ACD webpage to commemorate Dr. Adimora and memorialize her service.

With no further business posed or questions/comments raised, the meeting was officially adjourned at 2:49 PM ET.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the February 21, 2024 meeting of the Advisory Committee to the Director, CDC are accurate and complete.

____________________ Date

____
David Fleming, MD
Chair, Advisory Committee to the Director
Centers for Disease Control and Prevention

Attachment #1: ACD Membership

CHAIR
David W. Fleming, MD
Clinical Associate Professor
University of Washington School of Public Health
Seattle, Washington
Term: 10-01-2021 – 06-30-2023

DESIGNATED FEDERAL OFFICER
Debra Houry, MD, MHP
Acting Principal Deputy Director
Deputy Director for Program and Science
Chief Medical Officer
Centers for Disease Control and Prevention

MEMBERS
Daniel E. Dawes, JD
Senior Vice President, Global Health
Executive Director, Global Health Equity Institute
Founding Dean, School of Global Public Health
Meharry Medical College
Nashville, TN
Term: 09-28-2021 – 06-30-2024

Helene D. Gayle, MD, MPH
President
Spelman College
Atlanta, Georgia
Term: 12-11-2023 – 06-30-2027

Rachel R. Hardeman, PhD, MPH
Blue Cross Endowed Professor of Health and Racial Equity
Founding Director
Center for Antiracism Research for Health Equity
Division of Health Policy and Management
University of Minnesota School of Public Health
Minneapolis, Minnesota
Term: 09-28-2021 – 06-30-2025

Octavio N. Martinez, Jr., MD, MPH, MBA, FAPA
Executive Director
Hogg Foundation for Mental Health
Senior Associate Vice President, Division of Diversity and Community Engagement
Clinical Professor, Steve Hicks School of Social Work
Professor of Psychiatry, Dell Medical School
The University of Texas at Austin
Austin, Texas
Term: 09-28-2021 – 06-30-2025

Rhonda M. Medows, MD
President
Providence Population Health
Renton, Washington
Term: 09-27-2021 – 06-30-2024

Julie Morita, MD
Executive Vice President
Robert Wood Johnson Foundation (RWJF)
Princeton, New Jersey
Term: 09-29-2021 – 06-30-2024

Nirav R. Shah, MD, MPH
Chief Medical Officer
Sharecare
Palo Alto, California
Term: 09-27-2021 – 06-30-2025

Joshua M. Sharfstein, MD
Vice Dean for Public Health Practice and Community Engagement
Johns Hopkins Bloomberg School of Public Health
Baltimore, Maryland
Term: March 30, 2022 – June 30, 2023.

Jill Taylor, PhD
Senior Advisor for Scientific Affairs
Association of Public Health Laboratories (APHL)
Silver Spring, Maryland
Term: 09-28-2021 – 06-30-2023

Monica Valdes Lupi, JD, MPH
Managing Director for the Health Program
The Kresge Foundation
Troy, Michigan
Term: 09-27-2021 – 06-30-2024

Attachment #2: Acronyms Used in this Document

Acronym	Expansion
AAP	American Academy of Pediatrics
AAR	After Action Review
ACD	Advisory Committee to the Director
ACEP	American College of Emergency Physicians
ACEs	Adverse Childhood Experiences
ACPM	American College of Preventative Medicine
ADA	Americans with Disabilities Act
ADI	Area Deprivation Index
Alliance	Power of Partnerships Health Equity Alliance
APHL	Association of Public Health Laboratories
ARP	American Rescue Plan
ASTHO	Association of State and Territorial Health Officials
BHCU	Behavioral Health Coordinating Unit
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CFA	Center for Forecasting and Outbreak Analytics
CHL	Choose Healthy Life
CIOs	Centers, Institutes, and Offices
CMS	Centers for Medicare and Medicaid Services
COI	Conflict of Interest
COO	Chief Operating Officer
CORE	Cultivate, Optimize, Reinforce, Enhance
CPE WG	Communications and Public Engagement Workgroup
DEI	Diversity, Equity, and Inclusion
DEIAB	Diversity, Equity, Inclusion, Accessibility, and Belonging
DFO	Designated Federal Officer
DMI	Data Modernization Initiative
DoD	Department of Defense
DOJ	Department of Justice
DOT	Department of Transportation
DSW	Data & Surveillance Workgroup
eCR	Electronic Case Reporting
ED	Department of Education
ED	Emergency Department
EJI	Environmental Justice Index
EPHS	Essential Public Health Services
eQMS	Electronic Quality Management System
ERPO	Extreme Risk Protection Order
ET	Eastern Time
FAS	Freely Associated States
FETP	Field Epidemiology Training Program
FRN	Federal Register Notice
FY	Fiscal Year

Acronym	Expansion
GHC	Global Health Center
GRF	Graduated Response Framework
HBCUs	Historically Black Colleges and Universities
HCP	Health Care Personnel
HEW	Health Equity Workgroup
HHS	(United States Department of) Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
HIV	Human Immunodeficiency Virus
HRSA	Health Resources & Services Administration
HUD	(Department of) Housing and Urban Development
IOM	Institute of Medicine
JSU	Johns Hopkins University
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
MOH	Minister of Health
MoPH	Ministry of Public Health
MSI	Minority-Serving Institution
NACCHO	National Association of County and City Health Officials
NASOMH	National Association of State Offices of Minority Health
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCDHHS	North Carolina Department Health and Human Services
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCIPC	National Center for Injury Prevention and Control
NCIRD	Center for Immunization and Respiratory Diseases
NHMA	National Hispanic Medical Association
NIH	National Institutes of Health
NMA	National Medical Association
NOAA	National Oceanic and Atmospheric Administration
NOFO	Notice of Funding Opportunity
NQF	National Quality Forum
NWS	Director of the National Weather Service
OD2A	Overdose Data to Action
OGS	Office of Grant Services
OHE	Office of Health Equity
OPHDST	Office of Public Health Data, Surveillance, and Technology
ORCU	Opioid Response Coordinating Unity
ORR	Office of Readiness and Response
OSTP	Office of Science and Technology Policy
PCE	Positive Childhood Experiences
PHAB	Public Health Accreditation Board
PHDS	Public Health Data Strategy
PHE	Public Health Emergency
PHGF	Public Health Guidance Framework
PHIC	Public Health Infrastructure Center
PHIG	Public Health Infrastructure Grant
PHNCI	Public Health National Center for Innovation
RSV	Respiratory Syncytial Virus
R_t	Effective Reproductive Number

Acronym	Expansion
RWJF	Robert Johnson Wood Johnson Foundation
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SSDOH	Social and Structural Determinants of Health
STLT	State, Tribal, Local, and Territorial
SVI	Social Vulnerability Index
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
US	United States
USDA	US Department of Agriculture
USG	United States Government
VAP	Virtual Analyst Platform
WG	Workgroup, Work Group, Working Group