CDC Advisory Committee to the Director (ACD) Health Equity Workgroup (HEW)

Health Equity Workgroup Report

TASK AREA 1: Adopted by ACD on May 11, 2023
TASK AREA 2: Adopted by ACD on May 11, 2023
TASK AREA 3: Adopted by ACD on February 7, 2023

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Introduction and Background

The Centers for Disease Control and Prevention (CDC) has made considerable progress towards acknowledging the importance of equity in the agency's mission and the threat to optimal health resulting from racism and other forms of discrimination such as that affecting people from ethnic minority groups, people with disabilities, women, people who are lesbian, gay, bisexual, transgender or queer, and people with limited English proficiency. Leaders have undertaken the responsibility to develop actionable concepts to address the drivers of health inequities; however, strategic approaches and multiple action steps are necessary to ensure that the knowledge and understanding of these concepts are integrated into the day-to-day functions of the agency.

To this end, CDC has developed an agency-wide strategy that aims to promote health equity on behalf of everyone living in the United States. The agency's effort is known as its CORE strategy. CORE is an acronym for C-cultivate comprehensive health equity science, O-optimize interventions, R-reinforce and expand robust partnerships, and E-enhance capacity and workforce diversity and inclusion.

CORE offers an opportunity to develop and integrate consistent health equity measurement, approaches, policies, and practices. Among the CORE activities are the adoption of consistent equity-promoting approaches across different categorical programs as well as unifying cross-agency and cross-system action steps, from research agendas to surveillance strategies, from partner engagement to granting strategies. The opportunity for implementation of these approaches exists not only at CDC, but also more broadly for the state, tribal, local, and territorial (STLT) public health system in the United States. CDC's equity-related action steps may have a significant influence on their adoption at all levels of the system.

CDC's leadership has asked its Advisory Committee to the Director (ACD) to establish a Health Equity Workgroup (HEW) to assist in providing guidance on agency-wide CORE activities. In particular, the HEW was formed to focus on: 1) national data systems that assess and monitor racism and health and other drivers of health and healthcare inequities; 2) strategies that establish and sustain anti-racist systems of public health; 3) policy levers that advance health equity; and 4) multi-sector partnerships that accelerate the elimination of health inequities.

The HEW includes subject matter experts with experience in state and local public health agencies, non-profit community organizations, academia, health care, philanthropy, and civil rights and social justice. Its members include several ACD members as well as those selected from an open public nomination process. The HEW has

met for several months during which time it has met with numerous equity-oriented leaders from around the nation as well as with CDC officials.

Members of the HEW identified three major "Task Areas" to focus on in their initial review and consideration of possible action steps. These are:

- **Task Area 1:** How CDC's policies and programs can either facilitate community members' active engagement and partnership in eliminating health inequities;
- **Task Area 2:** How CDC can align and restructure internal policies, resource allocation, and program practices over which it has control to maximize the ability for staff and partners to address health inequities in their day-to-day work; and
- **Task Area 3:** How CDC can take decisive action, in concert with communities, to expand, embed, and integrate measurement and strategies to influence drivers of health equity across all public health programs.

The HEW first identified a set of seven cross-cutting obstacles and challenges that have impeded progress in health equity to date. Then, taking those obstacles and challenges into account for each Task Area, the HEW identified principles that should underpin approaches for improvement and suggested potential action steps for consideration by the ACD. The action steps for Task Area 3 were adopted by a unanimous vote of the ACD during its meeting on February 7, 2023. The action steps for Task Areas 1 and 2 were later adopted by a unanimous vote of the ACD during its meeting on May 11, 2023.

Health equity must be at the core of developing any intervention, innovative solution, policy, or programming for impacted populations, including the authentic representation of community members and their organizations. Now, more than ever, is the time for CDC to seize upon this moment in history and push for the advancement of health equity for everyone in the United States. CDC must work to ensure that strategies centered on health equity are paramount to making sure communities not only survive but thrive.

Obstacles and Challenges to Progress in Health Equity

Historically, across our nation's public health system, efforts to address health equity have encountered challenges related to community engagement, leadership, financing, and approaches. These obstacles have limited the effectiveness of well-intentioned efforts. The following reflects the most important obstacles and challenges identified by the HEW:

- ***Engagement and financing of community-based organizations (CBOs) have not been prioritized.*** Non-governmental organizations or CBOs are integral to achieving health equity. To date, there have been inadequate and inconsistent federal and state investments in CBOs for developing and implementing health equity initiatives. There is a disconnect between CDC's equity-focused commitment and the direction of its allocated resources. CDC predominantly directly funds state and very large local departments of health, not necessarily local organizations, smaller-sized local health departments, tribes, and territories. While there may be an expectation that these resources will ultimately get to communities where they are most needed, the extent to which that is occurring is difficult to assess.
- ***CDC Notice of Funding Opportunities (NOFOs) have historically lacked sufficient direction and incentivization for activities related to equity.*** There are current efforts underway to revise CDC's NOFO system. This is promising because the long-standing NOFO structure has offered limited opportunities to demonstrate impact beyond that measurable in short-term quantitative reports. The requirements of NOFOs are also often quite difficult for organizations that serve economically and socially marginalized communities to meet. Many NOFOs are limited to state, tribal, local, and territorial (STLT) public health agencies and so community-serving organizations are not eligible to apply. CDC's direct funding requirements as well as the funding requirements that STLT public health agencies may have for sub-awards often eliminate smaller and more under-resourced CBOs unable to adhere to complicated rules and requirements. In short, CDC's current funding mechanisms potentially limit creativity and community engagement and poorly incentivize organizations to center equity and develop sustainable solutions. One challenge to effective community engagement has been the lack of guidance that is community informed. Another barrier to constructive community engagement has been the lack of authentic representation and engagement of community members and organizations in the planning, implementation, and evaluation of CDC-funded programs. Diversity of community engagement at the federal level has been hindered by persistent biases and expectations that shape who is invited to participate in community-level discussions with federal agencies. As a result, there have been repetitive formats and rules of engagement that often do not yield productive results.
- ***System-wide leadership is lacking.*** Health equity-oriented approaches have historically been limited. They have suffered from inadequate financing and advocacy, and a lack of stable infrastructure and leadership across the public health system that, in concert, have prevented a prioritized and enterprise-wide approach to equity.
- ***Health equity approaches are isolated and inconsistent.*** Typically, public health programs have been organized and financed around specific diseases and health conditions. Collaborative efforts across programs have not been the norm. Measurement of condition-specific health disparities and short-term

solutions have been more common than those that focus on overall health and well-being and the underlying social drivers of health. While some programs like REACH and the Ryan White CARE programs have had strong equity-oriented components, these have been the exception rather than the rule. Consequently, measurement and approaches to health equity often have been siloed, narrowly defined, uncoordinated, and underfinanced.

- ***Attention is disproportionately focused on individual rather than community measures and actions.*** Health equity drivers often act at the community level, through influences where people live, work, and play. In contrast, public health programs are often more focused at the individual level, including both measurement of health status and program activities such as screening, counseling, and delivery of medical services including medication and vaccination. If present, public health-led community-level action often has been confined to public health, healthcare, and social service partners rather than including the non-health sectors that have a major role in creating social and economic environments affecting health -- such as housing, transportation, public safety, education, and agriculture.
- ***Timely and local measurement and evaluation are difficult.*** Many public health data sets have limited information regarding social and economic factors, meager or incomplete information on key demographic indicators such as race, disability, and sexual orientation/gender identity, and survey sizes that limit geographic specificity. Dependence on either research-based or national public health data sets has often resulted in analyses that are not timely, generalizable, or geographically specific enough for maximum usefulness.
- ***Approaches and framing are more often based on deficits and problems rather than assets and solutions.*** Over-reliance on deficit and deterministic-based framing can impede effective action, alienate, and disempower communities, and run counter to more positive community narratives. Funded entities have often been limited to larger organizations not led by or based in historically marginalized communities, further challenging community involvement.

Task Area 1

Enable and assure the meaningful involvement of communities in agency decision-making, the development of health equity policies, program implementation, and evaluation.

Task Area 1 Guiding Principles

- Ensure systems and processes are created and followed so that community perspectives lead and communities are meaningfully included throughout the decision-making process. There is no substitute for hyper-local community outreach and engagement. The most successful relationships with community partners are those where the central components are inclusivity and the meaningful involvement of diverse local organizations and residents.
- Build on strengths that match solutions to each community, rather than employing the same solutions for all. Communities invariably have many strengths and are resilient. Policies and programs must focus on interventions, building on community strengths and resiliency in addition to meeting unmet needs. Policymaking for inclusive governance should explicitly include community members by involving those who will be impacted by the policy to achieve more equitable outcomes.
- Health equity efforts cannot be myopic. Health equity across the lifespan is influenced by intergenerational and multigenerational experiences of trauma along with racism, ableism, sexism, classism, homophobia, and trauma. These and other factors must all be included in CDC's efforts to advance health equity.
- To achieve long-term positive change, routinely assess, map the effects, and intervene on the drivers of health equity on the health and well-being of affected populations and center on the principle that community development and sustained investment will yield positive impacts in the community.

Proposed Action Step 1

CDC should take specific steps to build and strengthen its relationship with underserved communities and CBOs that support them.

CDC has been appropriately careful to ensure entities that are potential recipients of CDC funds are precluded from participating in the decision-making process for determining actual awardees to avoid real or perceived conflict of interest. However, this practice may lead to isolation of CDC from key constituents more than necessary. CDC should expand its internal practices for ensuring community engagement and participation in its work, including consideration of at least the following:

- CDC should create an external council/process to provide advice and perspective from diverse communities to the new Office of Health Equity and to CDC as a whole.
- CDC should engage in a near-term process with CBOs to solicit their perspective and advice on the challenges of working with CDC and receiving funding from CDC, either directly or through sub-grants from STLT health organizations.
- CDC should work to include diverse community and CBO perspectives in the membership of its Advisory Committees that serve Centers, Institutes, and Offices (CIOs).
- CDC should routinely include appropriate community and CBO perspectives in its external program reviews and public health issues meetings and convenings that engage outside partners.
- CDC should prioritize the inclusion of "lived experience" as a potential job qualification in job announcements and position descriptions for internal staff who create and oversee public health programs.
- CDC should develop and encourage opportunities for internal program staff to experience the realities of opportunities and challenges in underserved communities and the CBOs that support them.

Proposed Action Step 2

CDC should engage with STLT public health agencies to identify and implement best practices to build and strengthen relationships between STLT public health agencies and underserved communities and the CBOs that support them.

The primary connection between CDC and communities referenced above in Proposed Action Step 1 is important, but equally important are the connections between these communities and their respective STLT public health agencies. STLT public health agencies are closer, both geographically and administratively, and are often the primary recipients of CDC funding for public health programs and practice in a jurisdiction. While most STLT public health agencies already have relationships with their communities, these could and should be stronger and more comprehensive. CDC can help by being part of the process of identifying the challenges and opportunities to building and maintaining these relationships, including near term changes in policy and practice to jumpstart progress. Examples of specific actions include:

- CDC should provide leadership in better connecting with communities, as in Proposed Action Step 1 above, and encourage appropriate similar action by STLT public health agencies. This would include fostering local engagements between STLT public health agencies and CBOs to solicit their perspective and advice on the challenges of working with and receiving funding from STLT agencies.

- CDC should identify and implement ways to harmonize practices and expectations across CDC programs and grants to optimize community engagement and involvement at the STLT level. This could include, for example, strategies to ensure sufficient time for community involvement in grant applications and program development, using common community processes and locally available metrics when feasible, enabling community work on common underlying conditions across multiple diseases and conditions, and encouraging or requiring concurrence/agreement on approaches from relevant communities in STLT grant applications.
- CDC should work with STLT public health agencies and community partners to identify best practices for strategies and mechanisms to ensure meaningful community engagement and leadership and should encourage or require adoption of these by STLT public health agencies in relevant CDC funding streams.
- CDC should identify and create opportunities, including funding opportunities, for enabling meaningful engagement between STLT public health agencies and communities, especially on issues relating to underlying drivers of health equity or health disparities. An example would be Disparity Impact Statements, which use is now encouraged by the U.S. Department of Health and Human Services (HHS), and which provides for specific funding following an award to a jurisdiction to "identify demographic, cultural, linguistic, social, policy, historical, and other context that helps unpack root causes or drivers of disparities for population(s) considered at highest risk for disparities, be data-driven (including qualitative input from experts, such as those with lived experience), and address how the project will reach targeted underserved communities."

The critical determinant for the success of Task Area 1 will be the recognition that meaningful "community engagement" requires more than just fostering opportunities for the community to provide input and instead requires community agency in the design of policy, program development, and program implementation.

Task Area 2

Align and restructure, as necessary, CDC policies, resource allocation, and program practices to maximize the ability for staff and partners to address health inequities in their day-to-day work.

Task Area 2 Guiding Principles

Center community and equity in policies and funding:

- *Recognize the impact of political and systemic power differentials on historically marginalized communities to facilitate policy actions toward equitable culture shifts and improved public health by embracing a culture of accountability for addressing long standing inequities.* CDC should build institutional capacity and support efforts to change the systemic structures that have perpetuated health inequities.
- *Strengthen and increase mechanisms that create increased opportunities to provide funding directly to CBOs as opposed to the traditional "trickle down" funding dissemination approach* from STLT public health agencies to CBOs. Sustainable community investments should be targeted across communities and multiple diseases and adverse health conditions.
- *Identify institutional barriers that have resulted in fewer opportunities for CBOs to access CDC resources, including financial and technical assistance.* Historical structures, systems, and practices within CDC have created barriers for CBOs to compete for funding opportunities. CDC should assess and transform administrative and programmatic barriers that have resulted in and perpetuated these structural barriers.
- *Examine and revise existing policies and laws for the existence of stigmatizing language and ensure that new policies exclude further stigmatization.* Stigmatizing language entrenched in laws, policies, and systems perpetuates and codifies inequitable treatment. Policies focusing on social and political determinants of health should be prioritized to offer upstream solutions and wrap-around support for communities disparately impacted by inequities and poor health and well-being.
- *Embed equity into all decision-making* from the OD to the CIOs and ensure a transparent, accountable, accessible, and inclusive process to enable cross-team communication and collaboration.
- Ensure that CDC's policies, communications, and programs are offered in a *person and community-centered, language-concordant, accessible, and culturally-centered manner*.
- *Scale equitable practices across the agency* that support the allocation of resources to implement cross-cutting initiatives focused on the social determinants of health.

Proposed Action Step 1

CDC should immediately initiate a coordinated, agency-wide assessment of all grants, cooperative agreements, and contracts across all programs, projects, and activities (PPAs) to establish a publicly available and accessible inventory of how funding is allocated (i.e., competitive, formula-driven, etc.), to which types of organizations (i.e., STLT public health agencies, CBOs, membership organizations, etc.), and where there may or may not be restrictions in the legislative language concerning eligible grantees. CDC should also develop an inventory which identifies the names and award amounts for primary grant sub-recipients for all grants, cooperative agreements, and contracts that are awarded.

Since the majority of CDC's appropriated funding does not seem to contain stipulations or specific requirements around grantee eligibility, there may be a fair amount of flexibility in the types of organizations that may be eligible to apply for grant programs. Historically, the majority of non-research funding flows from CDC to STLT public health agencies in both competitive and formula-based procurements. Programs do not seem to be precluded from expanding grantee eligibility criteria to include non-profits and community-based organizations, but the day-to-day practice results in funding, which flows through the governmental public health agencies. Establishing a baseline inventory of all grants and cooperative agreements as to explicit restrictions related to grantee eligibility will provide more transparency. Moreover, additional transparency would clarify how much funding remains within the primary grantee's budget and how much funding is actually being deployed in communities (e.g., from the state health departments to local and tribal health departments, CBOs, and/or intermediary organizations).

Proposed Action Step 2

All CDC PPAs should jointly create and put into practice a publicly accessible policy document for applicants and grantees responding to CDC Notice of Funding Opportunities (NOFOs) detailing requirements for integrating health equity processes and approaches into new or continuing applications. This document should include the elements of the HHS Health Equity Guidance for Notice of Funding Opportunities (NOFOs) and also the additional ACD recommendations derived from the HEW not contained in the HHS Guide. Activities would include requiring PPAs to conduct equity assessments in developing NOFOs and requiring all grantees to develop disparity impact statements as a condition to receiving CDC funding. These NOFO considerations should also be required for STLTs public health agency grantees as they re-grant or sub-award to CBOs in their respective communities.

As CDC develops internal protocols and procedures for implementing HHS NOFO Guidance to Advance Equity, all PPAs should be required to conduct equity assessments to better inform their NOFO application requirements

and monitoring of recipient and program performance. Additionally, grantees should be required to develop disparity impact statements as a condition of receiving CDC funding to ensure that grantees use a comprehensive data-driven approach for identifying and addressing disparities to promote equity for underserved populations that are expected to be involved in program activities. Internal guidance for PPAs should also be made publicly available to provide greater transparency in the ways that CDC is working to advance equity through its NOFO process.

CDC should build in requirements across all its NOFOs to integrate ways that grantees must routinely invite, involve, and compensate community members and representatives from CBOs in strategic planning processes and promotion of health. CDC processes and practices should strengthen the ability of CBOs to apply for funding, and these should also be incorporated into NOFO requirements for CDC's National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce (i.e., the Public Health Infrastructure Center) in the ways they sub-award to CBOs. Equity assessments will help determine how different groups, especially those experiencing inequity or disparities, may be affected by a program.

Proposed Action Step 3

CDC should develop more equitable systems throughout the lifecycle of NOFOs, from planning and development to selection and post-award support. All programs should be required to: a) engage community partners at the earliest stages of conceptualizing a new NOFO to develop a more credible, accessible, and relevant NOFO; b) develop application evaluation criteria that take into account equity factors or considerations, including evidence of community engagement in developing the response and project budgets that reflect compensation for guidance and leadership provided by individuals with lived experience; c) improve systems for strengthening and improving the accessibility of technical assistance provided to CBOs in the pre and post-award phases; d) develop webinars and other resources that are responsive to language, accessibility, and technical issues, such as access to broadband and screen reader compatible resources, which often present challenges for developing successful applications; and e) provide longer application submission timelines to ensure meaningful opportunities to engage community partners in planning and development.

Current processes may reward those organizations which are more experienced in developing well-written applications, often with the support of paid grant writers. Systems that have been designed to ensure competition have likely resulted in structural barriers which prevent smaller, lesser-resourced organizations from being successful applicants. Larger organizations with the infrastructure and resources to hire professional development staff and grant writers are more likely to be viewed as more competitive and this results in an inequitable system for funding.

These longstanding processes and practices have resulted in an inequitable distribution of CDC resources. CDC should transform these approaches to allow it to align resources more effectively with where the need is greatest. In reviewing or evaluating applications, CDC should consider equity criteria that reinforce the need to include communities in developing responses to NOFOs, for example, evaluating how applicants are integrating community-driven solutions and narratives and developing budgets that reflect compensating for lived experience and hiring community-based workforce. These are some examples of how applicants could be required to demonstrate more authentic community engagement and participation in the grant application. Additionally, CDC could provide special dispensation for applications that address the areas and communities of highest need and the increased use of base and/or formula allocations.

Proposed Action Step 4

CDC should strengthen project officer engagement by developing or redesigning training materials that elevate equitable grantmaking and emphasize the important roles they play in providing support to grantee partners.

CDC should strengthen efforts to build a culture of trust among its project officers to support a shift from a mindset of being subject matter experts or specialists to coalition builders and thought partners. Grantees experience lots of variability in the quality and types of technical support provided by CDC project officers. Therefore, CDC should develop continuous training and workforce development for current and new CDC staff that provide concrete examples or best practices for integrating equitable grantmaking and technical assistance in program and NOFO design. CDC should identify ways of building expectations around equity into human resources (HR) or performance management systems to incentivize equitable approaches for working with community partners.

Task Area 3

In concert with communities, take immediate and decisive action to expand, embed, and integrate approaches to measure and influence drivers of health equity across all public health programs.

Task Area 3 Guiding Principles

- *Transform our public health approach to health equity from its current, often disconnected and categorical construct to one of more consistent and integrated approaches and solutions that are enabled, incorporated, and financed across the range of CDC/STLT public health programs*. This process can begin immediately, but concurrent qualitative and quantitative research and funding are needed for longer-term success, including evaluation of measures, policies, programs, progress, and ongoing needs.
- *Adopt practices to ensure community engagement and partnership in the process of developing and implementing inclusive health equity measurements and interventions across programs and jurisdictions*. Careful attention to inclusivity and a deep commitment to true partnership will be key to success.
- *Focus attention beyond individuals to upstream community drivers of health*. Health equity is primarily determined by policies, systems, and environments. These factors are better and more directly measured and influenced at social, political, and community levels rather than through more traditional individual-based public health surveillance and program approaches. Special attention should be devoted to non-health sectors that have major roles in creating social and economic environments affecting health and success in these domains will also require further development of the necessary attendant skills in policy development, decision support, and advocacy.
- *Assure inclusion of health equity measures and actions that are asset-based*. Strategies and programs are often more effective and more useful when they align with implementing solutions rather than only identifying problems, when they build on community strengths, and when they are implemented by organizations with the connections and trust necessary to achieve results.
- *Enable measurement and evaluation strategies that are real-time, local, and trusted*. Data have the greatest value when they are directly related to actions at the unit of intervention in a time frame that can be used to influence programming. In concert with communities, data collection and surveillance systems should actively identify and dismantle biased reporting structures, improve disaggregation, and actively take steps to reduce the impact of racism, ableism, and other forms of structural and institutional discrimination on the collection and interpretation of information.

The HEW proposes two broad but related action steps, each with specific suggested initial steps. The first is related to measurement and the second to intervention.

Proposed Action Step 1

CDC should immediately initiate a coordinated, agency-wide approach to identify and implement measures of underlying drivers of equity and health equity in ways that make them accessible and useful to communities and public health programs. These efforts should extend beyond current practices to better disaggregate information by race and ethnicity and other measures of marginalized populations, which -- while critically important -- are often insufficient on their own to generate action steps. They should also extend beyond measures of individual status to ones of community, policy, system, and environmental determinants.

As part of this action step:

1) **CDC should lead a process to synthesize the current state-of-the-art of measurement of upstream drivers of health equity.** This process should include current STLT efforts as well as national and academic work, including CDC's network of Prevention Research Centers. The synthesis should include both qualitative and quantitative measurements and be informed by diverse community narratives.

2) **CDC should initiate a process with key partners and stakeholders to assess the feasibility of, and opportunities for, developing and using field-tested and consistent methods and measures across programs and jurisdictions**. Measures and methods should be developed in close consultation with communities and assure inclusion of the undercounted. Approaches will need to be customized to community; change will take time, and early successes may be partial successes.

3) **CDC should assure the development of indicators that includes asset and solution-based measures of individual and community equity and health equity**. These measures should be developed in close partnership with relevant communities and populations and in the context of community narrative.

4) **CDC should focus special attention on identifying and developing measures that can be timely, locally available, and as granular as possible**. To aid in both timeliness and geographic scale, expertise in "big data" should be brought to bear to enable reach beyond current, more limited public health information sources. Priority should be placed on making resulting data and information as widely available and accessible as possible.

5) **CDC programs should promote, and enable through program funding, the incorporation of measures of health equity into the monitoring and evaluation of all public health programs**. Measures should

include preparedness and response activities and should prioritize planning to ensure the availability and analysis of relevant data that can be disaggregated to the population of interest.

Proposed Action Step 2

CDC should immediately initiate a coordinated, agency-wide approach to develop and integrate strategies to influence the effects of drivers of health equity across the entire range of its public health programming. Key to the success of this effort will be routine incorporation and integration of this approach into most/all CDC and CDC-funded STLT public health programs (i.e., a system-wide approach extending beyond standalone or categorical funding for health equity and social determinants of health).

As part of this action step:

1) **CDC should align and integrate the internal organization and leadership of its Health Equity and Social Determinant of Health activities to assure coherence and synergy of approaches.** An organizational entity within the office of the Director should be empowered to assure accountability for the routine development and integration of strategies to influence the drivers of health equity across all CDC programs and activities.

2) **CDC should promote and enable across all program funding the routine assessment and mapping of the effects of the drivers of health equity on the health and well-being of affected populations**. These assessments should: 1) be performed in close coordination with communities: 2) include the range of relevant structural power dynamics potentially affecting solutions; 3) be geographically and programmatically informed; 4) occur at all phases of the project; and 5) routinely assess synergy or conflict with other projects or interventions affecting the same individuals or communities.

3) **CDC should promote and enable across all program funding, identifying and incorporating strategies to improve project outcomes by modifying the most important and influenceable dynamics identified in the assessments above (in 2)**. As part of this work, CDC should assure the development of multi-sectoral strategies and should take a leadership role in developing the relevant needed partnerships with the appropriate related federal agencies, for example in housing, transportation, public safety, education, and agriculture.

4) **CDC should assure that this suite of promoted and funded strategies routinely includes asset-based approaches directed at individual, as well as system, policy, and environmental drivers of health equity, including civic engagement strategies**. Funding mechanisms should ensure that affected

communities are engaged in the design, implementation, and evaluation and that resources are directed to organizations with expertise and roots within the communities of the prioritized populations.

5) **CDC should assure that measurement of these efforts and their effects are routinely incorporated into project and program evaluation**. Measurements should be timely, derive from logic models when possible, routinely assess for unintended structural and policy effects, and include early indicators of program progress.

Health Equity Workgroup Members

Name	Organization
Daniel Dawes, JD HEW Co-Chair	Meharry Medical College
Monica Valdes Lupi, JD, MPH HEW Co-Chair	The Kresge Foundation
Adaora Alise Adimora, MD, MPH	University of North Carolina (UNC) School of Medicine
Michelle A. Albert, MD, MPH, FACC, FAHA	University of California, San Francisco School of Medicine
David Fleming, MD	University of Washington School of Public Health
Rachel R. Hardeman, PhD, MPH	University of Minnesota School of Public Health
Rhonda Medows, MD	Providence Population Health
Julie Morita, MD	Robert Wood Johnson Foundation (RWJF)
Octavio Martinez Jr., MD, MPH, MBA, FAPA	Hogg Foundation for Mental Health/University of Texas (Austin)
Philip Alberti, PhD	Association of American Medical Colleges
David Brown, MBA	YMCA
Nafissa Cisse Egbuonye, PhD, MPH	Black Hawk County Public Health (Iowa)
Cary Fremin, BS	Dot Lake Village Council, Dot Lake Village
Delmonte Jefferson, BS	Center for Black Health & Equity
Maria Lemus, BA	Visión y Compromiso and Network of Promotoras Community Health Workers
Mysheika Roberts, MD, MPH	Department of Public Health – Columbus, Ohio
Bonnielin K. Swenor, PhD, MPH	Johns Hopkins University Disability Health Research Center
Paula Tran, MPH	Wisconsin Department of Health Services
G. Robert Watts, MPH, MS	National Health Care for the Homeless Council