>> HOST: -- for your convenience. I think it will be. We are getting our ACD members on video that are remote. Bear with us as we get everybody pulled up. I'm going to turn over to David to kick us off.

>> DAVID FLEMING: Thanks, and welcome members and the CDC leadership. We have an action-packed agenda. We're going to start with the CDC Director, and then following discussions on accreditation, CDC activities regarding mental health and overdose and Moving Forward and health equity and then (Indiscernible) we will conclude today and vote on a potential group. We have a busy agenda in front of us.

Role call is the first thing that we do. But for the record, November 2023 work group minutes have been finalized on the ACD website. And we're beginning the third year --

>> DAVID FLEMING: So we have a mix today of virtual and in-person. And we will go around for roll call. And declare at that time with any conflicts. David Fleming and no conflicts.

>> ATTENDEE: Jill, no conflicts.

>> ATTENDEE: Julie, no conflicts

>> ATTENDEE: Present. No conflicts

>> ATTENDEE: This is Rhonda. No conflicts.

>> ATTENDEE: Daniel, no conflicts.

>> ATTENDEE: Good morning, Monica, no conflicts.

>> DAVID FLEMING: I think Monica is in Hawaii. So great for you to be here, Monica.

>> DAVID FLEMING: I think Josh is on?

>> ATTENDEE: I think I'm here. Can you hear me?

>> DAVID FLEMING: We can hear you.

>> ATTENDEE: Thank you very much. Josh, no conflicts.

>> DAVID FLEMING: Has Rachel been able to join us yet? I know she was ill and on her way. And on a personal note, it's a delight for me to welcome our newest member, Dr. Gail. And she has leadership positions at the CDC and gates foundation and more importantly I've had opportunity to see her in action in multiple settings. Helene, it's great to have you on the committee. Welcome. Decoration of conflicts?

>> It's wonderful to be here. My life is totally crazy, out of control, too much going on. But when I get on the call to do this, I couldn't say no. CDC was my first professional home for 20 years. And it's part of who I am. So I thought if I could be helpful at the time that's critical in the life of CDC, I thought I could give back and be as helpful and supportive as ever. It didn't hurt that old friends and colleagues like (Indiscernible) long-standing [Chuckles] I think we started CDC within a year of each other. We have known each other all our career. Julie when I worked with in Chicago, in

Daniel, we overlapped as well. So it's a personal way as well. This is great. I'm thrilled to be part of this.

>> DAVID FLEMING: Thanks, and once again, welcome. We look forward to your participation in the committee and catching up on old times.

The good news is we have the required quorum so we can proceed. And for the ACD folks virtually, please keep your camera on. If you have a comment, feel free to wave your hands on the screen or speak up.

On a more somber and much sadder note, we're missing today one of our long-standing ACD members and a colleague and friend to many of us. Talking about Dr. Adaora Adimora who passed away. I speak for everyone saying that Adaora's presence will be missed. She was on the same health equity work group I was in and I got to see her in action. She was smart, clear, and wonderful contributor, and I think I would add not shy to her list of qualities.

I had the fortune to talk to her on things one-on-one about CDC communication and CDC leadership and communication. And in that sense, I think her -- I know -- her thinking formed the work group we're working on today. And we were fortunate for her to leave that legacy.

>> PANELIST: I echo the sorrow losing her. And when we were leading the communication group, we spoke to her several times. She mentioned she had an illness but she would champion and move forward. And I had the privilege to know her, we were in the academy classes of the induction. And we got to know her there. She was a pillar of light, working on the disease, health disparities. And that light is out. I saw so many wonderful rememberenses online, and I'm glad she was part of our group and able to share her wisdom with us.

>> DAVID FLEMING: Thanks, Deb. So Adaora, we will miss you. And because you cared deeply about public health and health equity, I think you would say to get on the with the meeting. We will honor that.

And again, it's my great privilege to welcome Dr. Cohen. Dr. Cohen, it's a pleasure to have you here.

>> DR. MANDY COHEN: Thank you, David. And great to be with you all this morning. I was glad to see everyone at the event last night as well that I thought was incredibly powerful. So thank you, Julie for doing a terrific job moderating that conversation.

I'm thrilled, Dr. Gale that you have joined. You said your life is so busy, I was like there's no way she could join. But I'm glad to bring you on board and looking forward to learning from your experience inside and outside of CDC and how we can take both of that to make the CDC as strong as possible.

And then to echo, David, your words about Dr. Adaora, as you know, fellow North Carolinian as well. Knew her work from North Carolina, and a huge loss. But you're right, she would want to get to work. But she was just a wonderful human being in addition to just her incredible professional contributions.

So certainly, greatly missed.

But what I wanted to transition and have a conversation with you, one, is like a very quick look back at the few months I've been here in 2023. I've been here eight months now. And then how we're

thinking of 2024 and talking a little bit about the committee that we've asked as we've thought about what we need continued work and help on.

Looking back at the last eight months, proud of the work of CDC. Recovering from a historic crisis that this organization had to respond to and was in the most intense readiness posture you could imagine. And honestly, recovering from that, learning lessons from that. I see that happening everyday and we're not done.

But I think you can see the successful in how we responded to the respiratory season and operating as one team across CDC with that work. It wasn't the flu team separately and the respiratory team. It was everyone pulling together from data to lab to workforce to our communications and lab work. And of course the rapid response, and the incredible scientific technical work. I was proud to see that.

Now, there's more work I want to see going forward. But I think it was a good opportunity to showcase that. Some highlights, I was happy for the team standing up in time for bridge access program with COVID across the country. And this working group stood up with our pharmacy partners. I'm proud of the data work that's happening to align data across diseases. So to be disease agnostic. And I think you've seen the visual water and how those tools inform our work. And Brennan is here, our chief advisor, thank you. And that team did an incredibly fast and remarkable job. And demonstrates where CDC wants to go. Putting great information in the hands of people so they can protect themselves and make good decisions for themselves and their family.

And I was heartened to see good engagement with our partner. We had two new vaccines we had to talk about with folks. We had the RSV vaccines for adults and for pregnant moms and immunizations for babies. And an updated COVID vaccine. So a lot new for folks. In addition reminding folks to get their flu shot. And we put a lot in the founder community. I think we're fore shadowing with the communication group, there's more today.

I just got back from an international trip, and I wanted to share what I saw there. One, I went to open our regional office in Tokyo. Which I think is strategically important place for us to be building diplomatic alliances, and making sure we have visibility in that part of the world. It's important to build partnerships with the Japan minister of health.

And we had a chance to go to Cambodia. And I saw how our investment in global health is protecting Americans every single day. The reason we chose to go to Cambodia, after 14 years of not seeing any avian influenza cases, we are looking into a couple. There was some from birds, luckily we're not seeing any human-to-human transmission. But it was an opportunity for me to see firsthand the entire 22-year investment we have made in Cambodia, right now, is protecting Americans and preventing avian flu from getting to that region and then coming to the United States.

We went to a bird market, they were swabbing the ducks, and running genome sequencing. And then we talked to the doctors, and where they ran the labs. Incredible turn around. And then we met with the graduates with the EPI program, who went out into the community, asked about symptoms, great public health on the ground. It was fundamentally built on trust. We are training folks coming from those villages.

It was worked to see. We have to remember the importance of that investment and how -- right, that work, that trust building, that investment is what is keeping our world safe right now.

So, it was really excited to see and if anything, we need to do more. I was pleased to see the ambassador of Cambodia continue to articulate how important the CDC work was in broader health, not just health security. So wonderful things.

Also to highlight for the committee a few pieces of additional dollars we were able to put out in the last year, we understand coming out of a pandemic where all the attention went to the COVID response. We're going to have to go back to "normal". We have to put new investments. We put millions into national outbreak and disease monitoring. And we were able to 390 million in defense testing and national water surveillance. Thinking about how we are getting to that important capacity building, that infrastructure, that has to be there to keep us safe.

Another 245 million in data modernization efforts, almost exclusively to our state and local partners. That was incredible. And reminding our folks, yes, respiratory response is important. But with 2024, what CDC is doing to protect health, we put $279 million in opioid action. So this helps the states do a better job tracking and understanding our opioid use. And you can't solve problems you don't see, so the CDC is doing a terrific job of data and evidence based practices.

And on the partnership side, a lot going on there. But to highlight for you, we released an action guide to promote mental health and well-being in schools. Or another partnership with our education partners. And it was see on teens and mental health. Again, how to turn data into action that people can use.

I was proud of that and you're going to hear in our 2024 priorities how we lean into that even more. And as we look internally into CDC again, proud of where we've been. The Moving Forward work was a lot of work. And that continues. But we've completed 75% of those actions we've committed to. And we are now moving into the next phase of it.

Let me move into our talking about our 2024 priorities and then I would love to open to questions.

So, we plan together as a leadership team, and clearly we want to look at this year but what are we building towards? In terms of the CDC's unique role in protecting health and improving lives. If that's the big vision of getting to an effective, efficient CDC that is protecting health and improving lives, with our expertise and investments in communities around the country.

2024 is focus of key areas that deliver on that promise. The first priority for us is around readiness and response to health threats. And making sure we are investing in that critical infrastructure or core capability that allows us to respond to health threat or environmental threat. And we need to be ready. And our platforms need to be extensive for that. Do we have the lab and capability? Do we have the data infrastructure to protect and respond? Do we have the response capability? And those are the unsexy things of contracts, the trained workforce, and ongoing ready to deploy.

And importantly, we need the people that are talented and can do this work. And that is really a top priority here. We have to prioritize. It starts with what are the top risks and threats we need to think about most? Are we building platforms towards that?

That is a whole of agency response. Again, disease agnostic to try to build towards being the best CDC that can protect health and improve lives.

The other three to go through in the readiness and response, CDC is the quarterback. We are the lead in the U.S. government in response to health threats. To these other priorities, we're team members. And the second priority is improving mental health. This is where our data, our expertise on best practices can help drive, improve, and reduce suicides, and reduce overdoses, and make sure we're partnering with those like SAMSU and SMS and the medical community.

I know you're going to hear more from Allison. I'm excited about that work. But it shows how CDC can be that great partner. What should SAMSU invest in? Let our data and best practices guide.

Next area is supporting young families. Again, that's where CDC need to be a critical team member as we work with others supporting young families. That is where I feel our prevention work shines. If you're thinking about wanting to get upstream as early as possible to prevent thing. That is about mom having a healthy pregnancy, that's about the first few years of brain development. It is making sure our kids get the vaccines they need and not food insecure. But it's also thinking about our caregivers and the parents. I think sometimes they think our work only child focused but it's family focused. And how to care about caregivers going through nar own challenges.

And maternal mortality, making sure the kiddos get the routine vaccines. I want to say 94% vaccine rate, of course, we would like more like 96 %. But kids are still getting vaccinated. It's still important. We're going to make sure we're doing that. But then to it focus on the family caregivers and focus on the diabetes prevention.

And the last area of focus is internally. We can't do that work well, we can't respond, we can't be a good teammate to SAMSU unless we are most effective here at CDC. And that means the next chapter of Moving Forward. We're calling -- I'm calling it -- One CDC. I want to see this agency operate as one team. That means we need to do critical things to have a world-class diverse workforce. That means training. That means recruiting. Dr. Gale, I'm glad you're here, that means continued partnership with our historically black colleges and others as we do that work.

But it's also about equity accountability and communication in the work we're doing. I think modernizing the communication internally is just as important as the communication we're working towards externally. How do we work together as one team? We have to have great communication internally and externally. I'm exciting about the investments we're making internally. It's going to help us excel in our data, lab, workforce, if we focus on what we're doing internally.

From a communications standpoint, I hope you see a big change in our web presence. It's how the external interacts with us. We are very close to launching what's called Clean Slate. We're archiving a ton of information that is not readily accessed. And we are making more prominent the things that are actionable for folks. I'm excited for the opportunity to reintroduce yourselves, if you will. And that's a lot of my time. Reintroducing the CDC to the public. How is CDC working in your backyard right now? How are we protecting your families health?

I think a lot of people got to know us through COVID, for better or for worse, and I want them to start thinking about their kids and their mental health. Or about their caregivers, or protecting them from 2023 being the hottest year on record, and on heat and health.

So, we're working on that. And we've asked you to think about a new working group that focuses on partnerships, engagement, and communication. It is so foundational, but I think we have to be experts, honestly, in partnering. I know we're experts in science and data, but we have to be experts in partnering and experts in communication. We have to do work there.

We have to reach the public in a trust ed way with important key messages where we can have people change their behaviors. Behavior change is hard. So we have to be the best at it. And think about how we strategically partner and do that better at the community level and big national partners that can bring scale to our efforts.

Those are the things, I think, we are looking for advice and help, and how to best structure that internally to support that work. And what does that look like when we're doing really well? I'm excited to hear more about that.

I know I talked a lot. I'm proud of the work. I'll turn over to you for some dialogue.

>> DAVID FLEMING: Thanks, so much Dr. Cohen. It's great to see how you stepped into this. You don't talk a lot. You talk the right amount. But I want to open up for comments or suggestions that the community might have for Dr. Cohen. So let's remove the slides so that we can see the committee members on the full screen.

And go ahead and open up now to committee members for, as I said, not only questions but comments and suggestions on the presentation or ideas for her as well.

[Pause for questions].

(Cross talk)

>> ATTENDEE: Dr. Cohen, thank you for sharing your comments and 2024 strategy. I love the fact that you're concentrating on mental health. It makes me think of one area, suicide rates across the United States are a critical component. One of those is the access to dangerous weapons. Mostly it's guns in the United States. And I'm wondering the strategy, given how politically charged it is, to how we can turn this around, in your opinion?

Suicide is often as impulsive, as we know. And half of almost all suicides are secondary to the use of guns. And I think it's an area we could make a huge impact and save lives. And as we know in the behavioral health that those who survive suicide attempt can still lead healthy lives.

>> DR. MANDY COHEN: I don't know if you saw New York Times this morning, laid out in an easy and compelling way about why actually taking away a method of committing suicide doesn't mean they won't find another. It's another paradigm shift. Thank you CDC.

As much as guns can be more of a challenging issue to work on, I actually hear a lot of consensus when it comes to focusing on suicide and gun safety. I think you're going to see us lean us -- we have to, half the suicides are with guns, for men it's higher. And we will look at gun safety. I think there's a number of places where we're already supporting on best practices. One it's almost an dispruatory. And we're talking about using red flag laws and understanding where they're implemented and what are the best practices.

I think there's a lot of ways we can bring data and breast practices. That is where CDC shines and where we'll put our folks. Thanks for that.

>> ATTENDEE: Early in my career, I did work in Oregon with adolescent suicides and found out whether a suicide attempt was successful, with guns, being overwhelming the predicter of suicide. So there is some consensus about that is possible. Josh?

>> ATTENDEE: Thank you, I'm sorry I can't be there in person. It's great to see you all via computer here. On the last point, I worked with the team on the red flag laws in Johns Hopkins to do ground round in a number of clinical environments. And there's such an interest in clinicians because it's so scary to them when they see people at risk, particularly kids at work. In some states, physicians can file protection orders. And there's best practices for that. And I think it's an opportunity to leverage a public health goal.

I raised my hand for something a little bit about different. I wanted to thank Dr. Cohen for the strategic focus at CDC. I have my Google alert set to you, Dr. Cohen. It's crashing my e-mail. It's both strategy which is important and you're modeling the energy that the Centers for Disease Control and Prevention really need. So it's really great to see.

I have a question as you're thinking about kind of the picture about process for the CDC. And whether you've thought about the way CDC makes decisions, difficult topics, and whether there's opportunities for improvement for there?

I've noticed that you've been -- the agency -- has been stuck in a swirling of news stories with the COVID guidance. Not asking about that per se, but it's a classic situation where everyone is angry about a statement by CDC not made yet. It's random stories from different perspectives. I wonder if this might be, or an opportunity to think about, how these things happen and come about. And how you're thinking about that.

>> DR. MANDY COHEN: Thanks for that hard question. Let me put COVID to the side. I think we're working hard on how we change decision making processes within CDC. And it starts with us actually working differently as a team.

And so even just yesterday in our senior leadership conversation, we were talking about how do we think about the alignment of strategy across CDC as opposed to it each center coming up their own -- it's good work and keeps up siloed. But if you don't ask the questions at a senior leadership level about how to invest in lab, and train our workforce in an aligned way, what are the priorities to set? So, that we have a bunch of new processes around our policy development.

Again, I think you, Josh, we have a new Deputy. And Andi is going to be here later for justice work to mature that process. I think you're seeing with different guidances we've done in the last six months, we've put those out for comment, for folks to give us feedback.

I think we're doing a much different level of engagement as we're doing that. Even internally, we didn't have that. But to go to COVID, I think that is just the most sensitive and obviously we're not ready to share things in the fact that it was out there -- again, those kind of things -- we don't have context. It was disappointing that that happened. We want to have an inclusive and collaborative process, but we also need the time and space to do that work.

It's a hard balance, especially when it comes to COVID. I think we're trying to mature the process overall. I think COVID is particularly challenging. I don't think it's going to set the bar in everything we're doing because of the nature of what it is. But we are moving in that direction of different processes internally, as well as how to get collaborative feedback from folks. And other kinds of guidance, like HICA guidance and the doxy pep for guidance.

COVID, unfortunately, continues to it occupies special place, it's a special snow flake. So don't internal that how do we that process is for all. But we're going to try to do as best as we possibly we can.

>> DAVID FLEMING: It is interesting to hear your perspective how unique COVID is --

>> DR. MANDY COHEN: My mom beat you. She's like what's happening? I'm like, oh, mom.

>> DAVID FLEMING: So Julie, Monica, then Helene.

>> So, thank you, and appreciate your comments. And I want to double down on what Josh is saying and the strategic approach in the eight months. You have a plan. And I love how you described the work, you've identified that the CDC is quarterback in some situations but a partner in others. So I think it's really smart and appreciate the work you put into it so far.

The other thing I was going to say is a question in terms of marginalized communities. We think about the impact COVID had on marginalized communities. How are those marginalized communities considered in your planning? I think many of us are backing away from equity, diversity, inclusion. But we know that our communities are impacted. So curious about how you're thinking of approaching that work?

>> DR. MANDY COHEN: Thanks for that question. I think equity work has to both be called out separately and embedded in everything you do.

Yes, of course, we have a health equity office, and ways of thinking about programmatic work and CDC work, I call belonging when I talk from a values perspective that everybody belongs.

But it has to be owned by everyone. It can't be the health equity team owns that for everyone and then we're done. I want to commend the CDC organization. It is the most equity focused organization that I have had privileged of being part of. It is great. It is a wonderful foundations. It is not something that needs to come top down. I see it everywhere that I look.

But I think the place that we need to continue to do better is on the understanding the realities of the community. And, I think, this is where that work group is really critical. I think that while we are -- it is not just enough to say, you know, ask the questions and think about interventions. But what I think about equity work, and may be this is, again, I'm more of an operational person, good operations is equity work.

What I mean by that, we think about vaccine access, you're saying is a piece of this. Not just collecting good race ethnicity data, but thinking in a systemic way. How the programs touch different communities and how the access points work from how do we manufacture, how do we ship? What's the access points, what's the price points? Who is talking about it? Everything, right? All that is good execution and equity work.

My work is more on equity operations, but I want to see that more in operational work. So CDC doing terrific work in the equity space. My focus for this year is getting it into the operations.

>> ATTENDEE: I really appreciate that. You referenced that when you talked about Cambodia about how important it is to be on the ground and get the work done. You're describing the work ahead. I appreciate that.

>> DAVID FLEMING: One of the people I most respect in Seattle talking about health equity. Many people think about health equity being an outcome. But it's actually a verb. So interesting to-think about. Monica?

>> Monica: Thank you. And thank you, Dr. Cohen, for providing us with updates on the evolution of the work and the priorities. I hear about the one CDC approach. And I hear in your response to Julie's questions about impacted populations.

Another thing I heard that was different that we're excited to hear. I'm particularly interested in how you're approaching the work is heat. The interactions of heat and health. And just picking up on what you lifted up in terms of seeing equity in action, I think a great example for someone like me to see external of CDC is to see the environmental justice index.

I heard you describe the work of interactions of heat and health. But I was curious if you could say how you would consider the work of climate change, health, and equity?

>> DR. MANDY COHEN: Thank you for that, Monica. I think we are putting a focus on the intersection between health and heat this year. And again, focusing on what is it that CDC does best?

Back to the fundamentals. So we're focusing on make sure we have good data for folks to build upon to make good decisions. We're working towards ways for everyone to be able to see a heat index, I was learning yesterday, 94 degrees in Miami is not the same as 94 degree in Vermont. We need to see how temperatures impact folks.

And how our environment is changing and thus the pathogens are reacting to it that. Whether it's vector, our mosquitos and tics and changing. And also whether it's getting defrosted in the North Pole. So we're staying on top of the infectious disease component with heat is important.

So, we have foundational blocking and tackling to do on getting the data right, getting the surveillance work to the right place and build upon that for, so what? What are the important things we need to do. If it's crawl, walk, run, we're still in crawl. I want to say that out loud. We have some work to do. But we're excited about the potential here because I think we have to go there in order to fulfill our mission to protect health and improve lives.

With 2023 being the hottest year on record, we have to do more in this space because the world is changing. Here on the environmental aspect and justice as we build forward.

>> Helene: Like everybody, I applaud the priorities and coming out of a time where people stopped understanding the CDC's mission and role and the clarity, I think is great.

But I think it poses a couple of questions and issues. And as you talk about One CDC it is hard in any organization to see you're prioritizing and not have other parts of the organization think you've

forgotten them. So in your concept to One CDC, anything you want to say on how to take the organization through that?

And I think in some of the comments that people made, some things get lost that are still important. The fact that equity is not necessarily strongly stated up front, it will be important to make people understand. And I think your description of an operational way of thinking that makes sense. It won't make sense to a lot of people because it sounds like it's getting demoted so. I think how you say that and the nuance of that that people think it's still important.

And I think in terming of the terms of suicide and issues that people agree on. But there's an issue that people won't agree on is homicide and gun control. And no matter how hard you try to keep in boxes that people feel more comfortable with, I think being prepared for the fact that there are people who will feel like you're turning your back on a large issue or others who try to pull you in. So thinking about how you want to position that and communities that are impacted by that; making sure that people feel like you haven't forgotten that. But still don't get yourself embroiled in whatever.

So good luck on that dance. [Chuckles]

And I guess -- it was a just a question you mentioned mental health in schools. Because I'm an institution of higher learning where it is such a huge issue, I'm just curious what you're thinking about schools, wall level, areas of potential partnership, etc.?

>> DR. MANDY COHEN: Let me take some of those off on the how. We felt as a leadership team that it's important our priorities are elastic enough that everybody sees themselves in that. And a one CDC that is diverse, focused on equity and communicating well. That is every single person at CDC no matter where they sit. Whether they are in HR or doing security out front and protecting us, or doing programmatic work.

I think our mission to protect health is very aligned with being ready to respond. And then there are two areas of focus and not everyone is going to see themselves in mental health and that's okay. But we're hoping to have these buckets that are elastic enough so that everyone sees where they fit in. And my charge for the leadership team is to help you understand how they fit in.

Thank you for good feedback to make sure that health equity is more strongly stated here. I don't think folks to think that because it isn't in the 1, 2, 3, 4 of priorities it's not. But you have to it take that and I'll take the feedback on how to make it stronger. Thanks for the feedback on the violence and homicide and how to get to that work.

My experience in North Carolina and working for a Democrat governor and majority of Republicans, we worked together on the things we could find consensus on. Start with consensus and build trust and put some wins on the board so we can show we can work together and then we take the next step and next step. That's how I'm thinking about it, at least through my tenure here, as I navigate to ensure CDC has what it needs to continue the work.

I see more consensus, but that doesn't mean there is other things we don't want to do in the future. But this allows us to build a foundation to show we can work on hard things together and go forward from there.

And on the mental health piece for schools, I know Dr. Houry is going today a whole presentation so I'll let her do that.

>> ATTENDEE: Hi. Thank you for all the work that CDC has done on labs. You've made a great deal of progress. There are still things that need to get going. And we're trying to advocate you get the money that needs to be done. I'm a virologist. I am worried about measles. There is measles all over the world at the moment. And the one that really scares me is polio. And vaccine rates keep going down. Don't people remember about polio? It scares the hell out of me.

That leads me to the point of a very sensitive issue of vaccine mandates. It's such a difficult subject in the world at this moment, but I don't think it's one that CDC can avoid. I've said it before, Americans don't like being told what to do.

So, how can we figure out a way to pros and cons, in a way that's not in-your-face and not confrontational and aiming at doing better not perfect. Because any progress we can make in increasing the vaccine rate is worth doing.

So, may be it can be a subject for the communication work group? But I think it needs to be a broader conversation of how we can do better at a country.

>> DR. MANDY COHEN: Great feedback. And on the measles front, obviously, we are tracking all that closely. And not surprising, the cases we see are folks who are not vaccinated. But we need to do work better.

And on polio, CDC continues to be partners in the eradication work and there's more work globally there. And folks have forgotten. It's sad we have short memories that these things are so serious. I think that's a great opportunity for this work group on communication. How do we continue to help folks understand those messages in the context of not seeing cases?

It's hard for folks to understand.

>> DAVID FLEMING: It's always a delight to have your here. And I'm always impressed how wide-ranging the questions are. It's touch questions but you're doing a worked job on that.

I wanted to change the subject a little bit. I appreciate the notion of One CDC. It's something CDC has struggled in the past, apart from the uncategorical funding coming into the CDC. And you're the Director at the state and local level. And there's amallegation rather than unified organization. That's in part because of the funding. So is there anything at CDC to recognize the barriers is the categorical nature of funding and the difficulty of using those funds across a state and local department to make those things happen. Is that something you could perhaps think about making improvements in?

>> DR. MANDY COHEN: Thanks, David, for that topic. It's something I think about often as someone who came from North Carolina. I was Secretary of Health and human services. So I had the opportunities to bring Medicaid and early childhood dollars. And we planned together. But I know that's the reality of every state. Plus you need leaders to sit at the table and braid funding which requires a huge level of trust between people who work together. That didn't happen over night in North Carolina. It took us a while it got there. It's hard, when you're given a certain amount of many, it's like, "Its mine.".

It's very challenging but doable. I think for 2024, we have very much focused internally at CDC, how to do that better. If we want to see at the state level, we need to role model that at CDC. Our budget structure will not change over night. So we need to come together as a leadership team.

And even in our data investments, that is a critical infrastructure or core capability that we need to have. Every program needs it. But we have 300-600 + systems because every individual silo built their own. Not that one is bad and one is good, there's probably ones that are better than not. But we have to right size that. That's both for effectiveness and efficiency of our budget. But that's hard because that requires change and investments in dollars.

So, we have to try that as a team and then have conversation wise the Congressional partners and appropriators, we already have, to talk about the data lab workforce, responsibility in global workforce. Those are what I talk with Congress already. It doesn't mean I'm taking my eye off the ball of TB, avian flu, HIV. But things can go forward if you have a stronger platform. That's operable and extensible.

You'll see in our 2024 plan is a down payment for that, and it's something you have to chip away over time.

>> DAVID FLEMING: We look forward to working with you on that. Our data surveillance work group is helping grapple with that on the number of data systems out there. And I think some of the issues around health equity and programs there is where co-investment and resources will make a huge difference as well.

Any other questions, comments, suggestions for the committee? Opportunity for last words. Thank you from the committee to be here. It's always heartening to hear you speak, and the progress, and how you've assumed to be the leader of the agency F.

>> DR. MANDY COHEN: Thank you. I really appreciate it. I've been reading the reports, and I'm excited about the launch of this new one to help further our work. I know everyone is so busy. So appreciative. Thank you, thank you for your time you've invested in this. Okay. Thanks everyone.

>> DAVID FLEMING: Great. Deep breath and we're going to move on. I see les is here. We're going to move on to Leslie Ann Dauphin, Director, National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce. I learned last night is finally being called the infrastructure structure. I always wondered what the acronym for that center would be. Dr., you have the floor.

>> LESLIE ANN DAUPHIN: Thank you, everyone. It's a pleasure to speak with everyone. It's been over a year since I spoke with you last. Sorry I could not be there in person.

We were thrilled with accreditation for the topic. CDC plays a major role in supporting public health departments through either direct funding support of partnerships and Freud providing tools and technical assistance. The accreditation program is managed in the CDC center and our division of partnership support.

I want to give a shout out to Liza, who I believe is in the room, who is leading this part for many years and is an expert in the area.

Today I will provide an overview of the program, CDC investments to support this program, the current state of accreditation by the numbers. And then share some evaluation findings. We've also posed some questions for discussion.

Thank you. Accreditation of health departments is really about standards and measures that are intended to raise performance and reflect current public health practice. These standards and measures are organized into ten domains and aligned with the public health services. It's a framework that promotes policies, systems, and services to enable good health.

I should mention that the latest version was revealed in 2020 as part of the futures initiatives, the Beaumont foundation and the boards of centers of innovation put out this new framework in 2020.

You'll see in the diagram, the new framework has health equity and they're embedded. And the standards include what health departments should give attention to while providing services to their committees.

Briefly about the program, the accreditation process takes about -- is about meeting standards, health departments are required to use either documentation or peer reviewed process. And it also involves site visits. Once accreditation is achieved, it is for a period of five years. At which point the health department can seek reaccreditation. The reaccreditation process is a bit more streamlined with few standards and measures while assessing the health department has continued to make process. So it's about continual quality improvement.

Now about the program. Next slide. It is a voluntary program. And the Public Health Accreditation Board service as the accrediting body. Following the 2023 report, CDC and Robert Johnson explore roles and what accreditation looks like. As you can see at the bottom the national accreditation program was established in 2007. The board was established in 2007 and the program was launched in 2011.

The first health departments were accredited in 2013. As I mentioned earlier, the accreditation period was for five years. So the first health departments were reaccredited in 2018. So the CDC has been making investments. We've been funding the program through cooperative agreements and support. And supporting the health departments in achieving accreditation.

Next slide. A little overview of investments to support accreditation. Since about 2005, CDC is consistently invested in accreditation activities. And this is from the PHAB through successive cooperative agreements.

At the bottom, the first cooperative agreement HMO8-805 is the core activities including accretion and the standard. And CDC been involved with the accreditation board.

In 2013 there are different sole-source for PHAB and OT13, and now the latest 2023 cooperative agreement with funding roughly between the dollars.

And through collaboration through CDC, RJWF implemented the 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. Next slide.

Would like to provide an overview. So what is the state of accreditation of health departments today by the numbers? You can see as I move from left to right, almost all state health departments are accredited. In terms of the populations served by health departments, 81% of the state health departments are accredited today. And more than 2,000 local health departments, 389, 17%, are accredited. And there are more than 80 who are currently pursuing accreditation.

With regard to tribal health departments it, six health departments are currently accredited by PHAB and there are several more in process.

I should highlight also that PHAB has contracted work with DOD to accredit all army installations departments of public health. So this is extended beyond state, tribal, local, and territorial departments. And there's the KR minister of public health. There are 111 health departments engaging in or eligible for reaccreditation.

Just about the pace of reaccreditation recently, from 2020-2023, there have been five states, 61 local, and two tribal health departments achieved reaccreditation states. The pace has slowed a bit, but we're at a point where fewer state health departments not accredited than accredited.

And the pace of local health departments between 2021-2022 was study with about -- to about 10 per year. It's important to provide contexts here. PHAB granted accretion to health departments during the COVID pandemic. Extensions were common and may account for some of the changes in PACs that we've observed particularly at the local department.

Just for an overview of what we're learning about accreditation. Since 2013, north at the University of Chicago has conducted surveys of health departments when they reach certain milestones. So this is after post accreditation, four years after accreditation, and throughout the process. The goal is to collect data to learn that process, process improvement, and document outcomes to inform decisions about the future state of the program.

And the results are self-reported and they have an opportunity to share their successes as well opportunities for improvement.

As we run through the data, there's a few we can see here. You can see that 95% who reported in a post accreditation survey, and the denominator here is 281, indicated that they saw improvements, quality, and performance. This is self-reported data from health departments with accreditation post one year accreditation.

78% indicated accountability and transparency. This is from the same set of data. Post accreditation one year, denominator 291.

And some have reported relationships with new partners have been helpful. This is from a survey conducted at year four of question, the respondents were 204 that participated in that.

Now, with regard to reaccreditation, some have reported a decreased perceived value or benefit as a challenge of reacorrection. And this is from a survey of 77 participants between 2020 and 2022.

So, there's several items we're paying attention to. Challenges we've heard regarding reaccreditation have been related to staff time, turn over, and challenges in leadership. And we've

engaged in the state and local levels that there are some burden perceived particularly to the cost and amount of time and the effort to achieve accreditation. Next slide.

So, I want to pause there because I would like to entertain some questions we've posed here around CDC's role. And how we can work better to help public health agencies improve the quality of serves. I think that's what Dr. Cohen was interested in.

How should we think about the new standards and measures? And what role should CDC offer to public health agencies to help support the efforts? We've worked on incentives, and also trying to identifying opportunities as we work with PHAB and other organizations to provide technical support. And to really really see if this is achieving its intended outcome.

And how can CDC help address the barriers as in the previous slide.

I will leave you with that, I will pause and turn back over to you.

>> DAVID FLEMING: Thank you to that information on this important topic. You've raised a number of questions. I'll open to the committee for questions. Josh?

>> Josh: Thank you for the great presentation, Dr. I really appreciate it. And I know how much progress you're making at CDC to support state and local health agencies.

So my general comment is that the pandemic caused introspection in public health. How things are going in huge variations in responses across the country. There's been all kinds of after action reports. I'm wondering if there's been the same for accreditation. There's areas that have been trumping accreditation that have struggled a lot. And the after action reports have been brutal on the health department's ability today basic things during the pandemic. And they were accredited.

I appreciate the huge focus on QI, you see that in the north report. That's important for public health. I'm not trying to say that public health accreditation isn't valuable. But is there any introspection? And that states can get accredited even if local states aren't accredited. And the accreditation tends to be organized to what the state is doing and can the state do this? Not so much that the services and coverage the people in the state can count on. I wonder if that introspection is important? And can manifest itself in CDC listing potential changes to accreditation during the pandemic. I'm a supporting of accreditation. But I think playing by the same play book makes sense given what we learned in the pandemic.

>> LESLIE ANN DAUPHIN: Thank you, Josh. I know we had discussions about this over the last a couple of years. That was a lot. I'll start with yes, yes, and yes to all three. We've had a lot of internally. And really thinking about, one, how to -- kind of goes to my first question, how does CDC assess if accreditation is really helping public health agencies improve their quality of services?

When looking at the state level, to your point, yes, states can receive accreditation and local health departments working at the community levels may not. And they have different types of burdens and challenges.

One thing we can look at what you're mentioning Josh, we have a few impact studies that are ongoing. The Public Health Accreditation Board has funded three to look at what you're asking

about. How to look at the impact of accreditation, and looking particularly at the local level to overcome the burdens.

And there's a second study looking at the impact of accreditation in different areas like Ohio, for example, is the only state that mandates the accreditation of their local health department. So that's other data.

And a third is experience of accreditation among small state, tribal, local, and territorial and actually freely associated states. We're looking at learning from those, and really seeing how to help overcome burden these areas where we know it's extremely challenging to receive accreditation.

To your point, we've recognized the diversity of health departments and the services they're able to provide.

A lot of ways to look at that. It's an ongoing discussion and plenty of work in this area.

>> DAVID FLEMING: Thanks, I'll go to Julie next.

>> Julie: Thanks, Dr. Dauphin. I don't know where to look. Is the camera there? There?

>> ATTENDEE: We can see you.

>> Julie: Thank you for acknowledging our support in the past. But as a large city health department that got accredited. I've been through the process of acorrection. Thinking about what Josh said, what is the bigger question? The accreditation is a process for demonstrating that health departments can do certain things. Box checking. In some ways I felt like the process was a box checking activity. But the real question is what are the core capabilities that all health departments should actually have?

It's what Dr. Cohen talked about. It's less about the sillode areas within the organization. And holistically what the department needs to have and whether the CDC can support to make sure those health departments have what they need to be effective. That is the challenge. In Chicago we would get our siloed funding based on the disease process or issues.

What we lacked was core funding to step back and say, we are an organization that is capability of all these. And there was a time when CDC did that. We had that support and it was valuable. But then the funds went away. And I think it's important to look at accreditation and this is a process of saying that health departments -- can do what they're supposed to do.

But may be the role isn't about CDC and accreditation but what is CDC's role in making sure they have that capacity. We weren't getting the funding we needed. So we were reliant on the federal funds. I want to challenge you on that.

>> LESLIE ANN DAUPHIN: I appreciate you raising that. The funding is probably one of the biggest challenges we learned that we faced. I want to mention something. Since we talked about what is CDC's role supporting here? Yes, we agree there should be standards and measures, and yes we agree accreditation is a way to measure whether or not a public health department has achieved those measurements or standards.

But CDC helping them achieve the level to help their communities is what it's all about. With regard to funding, I ask have mentioned, one of the ways we can try and would love to continue to support at the state and local level is building the infrastructure so they can provide the core capabilities.

And one of the way CDC is doing that through a very small and new appropriation that helps state and locals to do the funding to build their capacity in the areas they see fit. And that's through the public health infrastructure and capacity line.

Outside of that and supporting at the state and local level, we really -- I mean, it's a struggle to really build those functional capabilities. So what we need is more sustained funding to help state and local organizations build their capacity in ways to do so to meet their needs

>> DAVID FLEMING: We may have more discussion on this point.

>> Daniel: Hello. Thank you, Dr. Dauphin. You talked about very difficult issues. I appreciate it. I noticed the focus on state, and the passion of my is the U.S. territories. I visited the virgin islands and Puerto Rico. I'm curious whether this program allows the U.S. territories from joining? And I noticed the local health departments, I noticed 389 participating in accreditation, but there are far more that have not been included for accreditation purposes. You listed the top three reasons for accreditation, I'm curious for those who haven't sought accreditation, what are their top barriers? I'm curious, your thoughts?

>> LESLIE ANN DAUPHIN: Thank you. One of the ways we're trying to help territories and freely associated states, and others, achieve accreditation is through the public health infrastructure grant program. I think I briefed this group briefly a while back. Right now, we have one territory in process of trying to receive accreditation. But they have unique challenges. It comes to capacity. This is same at the local level. Having personnel in place to work on this and go through the process of accreditation.

The second is funding. What are the some of the barriers? We know funding is a challenge. Having the capacity to focus on this and having the funding. We're trying to do our part not only supporting PHAB, but also the other mechanisms, for example, the funding infrastructure grant to get funding out and help encourage and incentivize accreditation.

And also our division of partnership provides tools and technical assistance. We're diving deep. This is a complicated, large, and challenging approach. But we're really trying to help those having difficulty where we can.

That's why I'm engaging you, it's helpful, we're interested in things we can do to help those facing unique challenges.

>> ATTENDEE: Thanks for a great presentation. Two questions, one, now that you've gone through one accreditation and reaccreditation, what are the lessons learned? And are there things you would consider, modifying, evolving in some way to make it more effective? And the second is, clearly as everybody has pointed to in one way or the other, the real goal is building the capacity at the state and local level. One of the biggest challenges is the resources. What to think in terms of advocacy so those who could provide funds could understand the core importance of this?

>> LESLIE ANN DAUPHIN: Thank you for that question. To your first question, I will say the Public Health Accreditation Board, PHAB, continues to document and learn from the challenges and successes of those who are achieving accreditation.

So, we document that. NOR continues to survey so we continue to hear from the health departments. And that will help to help with the latest version of standards and measures, I think, released in 2027.

This is a field-driven process. We document the processes learned, direct engagement at the state and local level, and what our partners are learning.

In terms --

>> ATTENDEE: Could I just kind of double click on that one? I guess what I was asking are there big lessons that you have learned so far that would be useful to share? Any specific things that you think you've learned from the ongoing evaluations?

>> LESLIE ANN DAUPHIN: Well, first I would say that some health departments that need help. The biggest challenges we're hearing about our own workforce, we talk about this as much as we can, I don't think we need to talk about the challenges, workforce challenges facing state and local levels.

They simply do not have the people it takes to really implement this. So one of the ways we are trying to support that is the public health infrastructure grant which had funding to support. That's one way.

In terms of advocacy, we try to educate as much as we can, particularly on Capitol Hill, the need for sustained funding to support our public health workforce. And we also work very closely with partners that they too have a part to play here in educating as much as we can about the need to sustain our public health work force.

Without those boots on the ground folks at the state and local level, we can't move forward. So we consider this a precious asset. I don't know if that addressed it --

>> ATTENDEE: I should have said educate not advocate. I've been out of government too long [Chuckles]

>> ATTENDEE: Hello, Les. I want to talk about what Josh mentioned. I want to talk about the labortry in the health department. And many laboratories are looking what they do. And it's not a strategy planning process but is the menu of our testing appropriate for the world we live now? And in many cases, they got this sort of, well we've been doing testing X for 20 years. Should we still be doing it? Or is that something that can be contracted out, more inexpensively, to a high commercial lab?

And their readiness capability is not good. So I was wondering if part of the accreditation process, is there a step before of accreditation of thinking is what we do supporting our community? And then accrediting based on that of who I am now, instead of who I should be?

I'm wondering if that should be a valuable thing? It's not every health department. I echo what Julie said, I went through the accreditation process in New York. And to a large extent it was check the box and questions that didn't really relate to us as a lab in a health department.

So I'm wondering if there's some rethinking about the preparedness for the future and reaccreditation?

>> LESLIE ANN DAUPHIN: Thank you for that question. We could talk separately at length about the laboratory part. I think you know my background in laboratory science and HPL over the years. I think to your point, really, the accreditation process could, and should be about capabilities. What are the capabilities that a health department should have no matter where they're at, local, tribal, the froly associated states to serve their population.

Do do we have the capability and ability to support and protect our communities? Thinking about how to look at these measure in a way to support a variety of settings is a bit of a challenge. I would say that one of the things that PHAB has done to think about this is they have created a pathways process. Where a health department may have some difficulty in achieving the standards and measures outlined through the accreditation process. So it's a more streamlined way to look at these are the basic ways on how we should support our community.

It's another track to help health departments look at accreditation while they're looking at capabilities that they may not be able to achieve right away. That's one of approach how this is has been address. .

>> DAVID FLEMING: Rhonda and then Monica.

>> Rhonda: Great presentation. I heard a preview of your speech, you did well. Did you work with ASO and NACCHO? Is and they provide assistance?

>> LESLIE ANN DAUPHIN: We partner with ASO and NACCHO in a number of capabilities that provide technical support. ASO is a major partner as PHAB through the infrastructure grant. And through the public health infrastructure grant, incentives accreditation and encouraging can these funds help achieve accreditation. And if you're not interested, we're trying to find out why? And what are the barriers where we can help you. Absolutely. The partner piece is very important to this.

>> DAVID FLEMING: Monica.

>> Monica: Thank you for sharing the updates of public health accreditation. In a previous life, I was at a large urban health department, and we did get accredited. It was more than a check box exercise, there it was all pre-COVID, all hands on deck to keep the emphasis and focus on accreditation and eventually becoming accredited.

I wanted to talk about the data you shared during the decreasing numbers during the pandemic and after COVID and the number of locals, in particular, that are becoming accredited. Whether CDC and PHAB is talking about. You emphasized capabilities. And I'm wondering if there's a connection between incentivizing and accreditation. And if how departments work on a day-to-day basis. I think the interest and recognition that accreditation is there, but there's the will and lack of workforce as you pointed too. I'm wondering if there's other ways explored through FIG and resources with the cooperative agreements on attaining and rebuilding trust in creditability and the great work our health departments have been doing.

>> LESLIE ANN DAUPHIN: Thank you for that. That is actually one of the ways which we try to educate officials is by highlighting our support of accreditation. We recognize that's something that policy makers understand. They understand standards, measures, external bodies coming in to say that an entity has achieved a level of standard. And that has been documented by external entity.

Certainly, we use every point we can to talk about this in terms of tying it back to credibility, if you will.

I want to go back to what you mentioned and also a question that came up that I don't think I addressed directly. About incentivizing this. With the funding providing through the public health infrastructure grant, and the cooperative agreements that have been used to fund PHAB and our work and partnerships with other organizations. We try to incentivize. And I think a lot is done at the state level to help incentivize their local health departments to help achieve accreditation.

Whether there's an opportunity to either provide support or additional funding that we can, we will try to do that. The technical assistance is another way we try to help.

Another study conducted in 2014, it looked at what are the incentives we're hearing from the field that are helpful. And what are the barriers we've heard of trying to go accreditation.

This is, again, where our partners can help. I hope that addressed your question. I'm touching on a few things here.

>> DAVID FLEMING: Thanks Les, Octavio?

>> Octavio: Great presentation. Hard work. Pardon my ignorance, is interoperate ability part of the standard on what needs to happen across the United States?

>> LESLIE ANN DAUPHIN: That's a great question. Not going to it answer that directly. I want to make sure I give you the right answer an answer. But I think a technical expert is there. Lisa, if you're there, can you address that question? I want to make sure I get this right. Calling on an expert.

>> DAVID FLEMING: ELISA is here.

>> Eliza.: You're speaking to interopera built. And there have been increasingly rigorous levels of expectations around data, data sharing, data use and what they're showing with systems with the successive versions of the national standards. That's an area, with the different versions since its launched, has increased each time.

With this last version, we worked closely with individuals and experts from both the data modernization initiative as well as what was at that point, preparedness now, and readiness and response, to ensure there was a lot of synchronization of the expectations around preparedness and certainly around surveillance systems and data modernization and data operability opportunities.

>> ATTENDEE: Is an incentive to be accredited then? Because of the focus on interoperability. And to be able to have the data that's necessary to it take care of our communities?

>> ATTENDEE: I think the accreditation is looked at more as a tool to move in the right direction and a lever to further advance the DMI opportunities. And the same point can be made with some other areas where accreditation content has increasingly addressed such as health equity and workforce training opportunities and partnership development.

So it's been a raising all votes and continuing to raise the votes that are already on the ocean to continue that analogy. So I think it's less than incentive. It gets us to the incentive point for those that are accredited, what could be asked for in an area within CDC, application processes. Or the connections with expectations in NOFOs or for grantees and how that might relate to something they are doing for accreditation or vice versa.

>> LESLIE ANN DAUPHIN: Ideally, we would like to see the efforts working together. As Liza mentioned, looking at NOFOs. At CDC we have an internal grants governance board to look how to use this to support the field in the best way. Either through stream line processes or learning from the field to ensure we're doing our best there.

And the work with the colleagues about the data initiatives. To learn about the funding and standard and measures that Liza mentioned. All this, the partnerships, the funding, technical assistance, and the work around data readiness, should be working together to support the field and achieve the capabilities to help best serve and protect the communities.

>> DAVID FLEMING: Thanks, les. I want to ask you a question, Les, I've had the opportunity to hear on you speak on this before. I would like to gently raise an issue of whether we're evaluating this program correctly. In my history, as an epidemiologist in Oregon, Oregon has a mix of health departments. Some who are highly competent, and some in rural are not financed no matter how good the workers are. Yet any county can put up a sign and say we're a health departments.

In that context, I'm not sure our goal should be to get all health departments accredited. But more how to have those capabilities present to get accredited. There are many health departments who do not have those and should not get accredited.

When talking about evaluation of accreditation, I'm not sure of the process that accreditation will make my health department better. If I'm able to pass the process, I'm able to provide those serves to health departments who are unable to be accredited.

When talking about the had accretion is successful, I'm puzzled did it help those health departments, given there are some that are accredited and not, can we tell the difference between those that are accredited and those that are not. That's powerful by accomplishing something with accreditation and showing the health departments that could do their job and pointing to those who need work in achieving those foundational capabilities.

>> LESLIE ANN DAUPHIN: Thank you, Dr. Flemming. Great points. To your point about the those who have achieved accreditation whether or not they perceive the quality of their services and accountability and transparency has improved, that is a real question how we should think about funding.

The previous current studies under way that PHAB is looking, they're looking at impact, I believe those studies are showing those who have achieved accreditation and not spacing those that has you mentioned. Something we'll think about.

>> DAVID FLEMING: Thank you, Les, we're out of time on this session. Thank you for coming to the committee to present the issues. I think it's a good discussion and looking forward to hearing from you in the future on how things are going.

We appreciate you being here virtually today.

>> LESLIE ANN DAUPHIN: Thank you. Always a pleasure.

>> DAVID FLEMING: And we are at break time. We will reconvene at 11:05 with mental health and overdose. Thanks so much, folks.

[Break time].

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>> DAVID FLEMING: Okay, folks. We're going to go ahead and get started. If I could people to take their seats? And -- okay. We have our Zoom folks back on board.

So many of us have been looking forward to this presentation on Mental Health and Overdose. We have two expert folks to talk with us. Deb and Allison is. And then move to Allison Arwady who is the direct for the national center of intervention and control.

>> ALLISON ARWADY: And the work is of mental health and overdose. And there's a coordinating unit that has morphed into behavioral health unit.

And that's pulling the strategies from the different centers and unified approach. It's a baby unit right now, in the incubation stage. But as we get permanent leadership in place, it will help lead a lot of efforts. I know Charlene presented on the collaborative initiatives -- oh, look at that. I didn't need a prompt -- and substance use will be part of this. And similarly, we participate as a center and agency in HHS efforts. SAMSU leads on services and research. But we bring the data and community level interventions and co-chair the suicide prevention work group as the coordinating unit.

One thing Allison and I will be tackling is looking at the data. I have 60 pages of information on our drug overdose and mental health data. And we're going to see what we can tweak on the dash boards to be more interactive. And seeing how to be nimble to evolving changes.

And we want to see what progress we're making. That's how this fits together an agency level approach. I'm going to turn over to Allison to talk about the injury center where much of the efforts lie.

>> ALLISON ARWADY: Nice to see folks about a month in. Ready for your questions to follow-up up afterwards.

We're excited about this --

>> , excuse me, please use your mic.

>> ALLISON ARWADY: Sorry about that. We're excited about improving mental health in the agency. I don't think it's the obvious choice for CDC to take this on. But I think it reflects what the country's needs.

And we have things that are affected by that. And that's preventing suicide and childhood adverse events.

We will highlight the data and how we are funding and moving data to action. Which is a goal for our center and a goal for mental health.

And how to set up prevention activities. Again, carving out CDC's role explicitly in these spaces is important. Lots of partners.

I don't have to tell this group, this is an enormous problem. More than 300 deaths happening a day. It's the number one cause of adults for ages 18-45. It's only getting worse

A paper showed in 2010, for every 20 times were coming to departments for non-fatal overdoses, seeing one fatal overdose. Just between 2010 and 2020, we are now seeing non-fatal overdoses for every fatal overdose. The pathogen is getting worse. We're seeing fentanyl in the states. And we're seeing amphetamines and it's more important in that prevention space for us to be thinking up stream and preventing overdose and staying on top of data.

On the left is a flagship programs and cooperative agreements. The first release was in 2019. This was relatively newly funded work. And we just released a second round this last September. And newly, we are now funding both, all of the states that applied, everybody except North Dakota is being funded. And we are funding some local jurisdictions. You can see $280 million, a lot of money, to help build the infrastructure and action work on the ground. As a former recipient of Chicago, this was critical to get EPI based for us, and building experiments on what could drive the needle, we have lofts examples how people are using this funding to make it more timely, more comprehensive and actionable.

One tiny example in Louisiana where we saw work similar to other grantees, they pulled folks from law enforcement, first responders, coroners office, a reduction it team. And they chose on the gaps, and they were going to focus on hospital departments and make sure everyone was going home. And they saw next year a 35% reduction in overdose in that parish. That's what we want to see on the ground.

On the right, each of these three, I'm going to highlight, addition to the funding work, we are lifting up the best evidence. This is meant for communities and partner said to use. We're rebranding them as sources for action. The idea is the thing in the space that work and there are things that don't work well and don't have evidence. And the opioid settlement money, we want to make sure that the work they're doing has evidence behind it and data to action framework. That's overdose.

On the next slide. Not going so well. Suicide deaths are going up 2% per year. That is about 135 suicides every day in the U.S. I'll note this pretty sobering static from the YBRS data in 2010 where

High School students not only thought about actually attempted suicide. And this was in people who took the YBRS that follow year.

We know that suicide lands disproportionally on certain groups.s veterans high risk, tribal populations and, youth.

And some of the data action we're fund, we have 24 grantees from the comprehensive suicide prevention. You can see this one is about $21 million. Les than 10% of what we have for the overdose work. But it's critical.

On the data side, this is doing things like recipients are able to look at emergency department data for those coming in for suicide attempts. And what are we doing to make sure those folks get the treatment they need to stop a completed suicide?

And we got the resource for action whether they're funded or not. And there's coalition work. There's a lot of work thinking about mow to take away stigma. And certainly healthcare providers and coaches and faith leaders and teachers and others have more ability to have it be a piece of what we're doing.

CDC is very focused on the prevention space here. We know that mental health is not the same as suicide. It's a contributor of suicide about half the time. There's a lot of impulsive things, a relationship issue, job loss, or monetary type thing that will often drive a decision around a suicide attempt. And as we see a lethality go up, there's more to do on that side. But there's a lot of to do on the prevention side.

We can go to the forward to the suicide. The last thing I'll say, and Deb mentioned this, in the same way we got this data to action framework happening with the grantees in Michigan, for example, they funded a sued it prevention media campaign and they were able to show the those exposed to it, and at the national level, in April likely, we will be releasing the White House's new national strategy for suicide preventionm this is colead between CDC and SAMSU. It's a strategy and three year action plan.

It's agricultural and labor are committing to actions around suicide. And its a big deal, it's exciting. We want folks to know about it. And have penetration with the resource action.

The next slide is around adverse childhood experiences. You might wonder why this is in there? This doesn't have the immediately feel of those dying every year. But in a prevention lens, this an important one. I assume you already know ACE and know that data. It's remarkable, if we can present that ACEs and have the positive childhood experiences to balance out the adverse childhood experiences, we would likely see big impacts on clinical health conditions. And we would see 44% fewer adults being diagnosed with depression. To treat our way out of the mental health crisis, that piece is critical.

Many adults experience those events and the risk goes up. The program, this is about $6 million as opposed to 280 we have for overdose. But we have 12 recipients and its a mix of states and hospitals, etc. and data drives it to action. And there's an action on what the evidence, and what works.

In Georgia, the recipient on the left was able to look at ACEs data and look at interventions for early childhood home visiting in the states that had the biggest gaps.

Overall, I hope this gives you a sense of how we're attempting to tie in the work and the funding and the work to get this out; to turn data into action, and turn action, and these are related, and preventable and they link into the mentally ill crisis.

Appreciate the interest. Deb and I will take questions together. I'm interested in thinking about more explicitly the mental health framework and how we differentiate the CDC's role in this larger piece. And curious about the thoughts you have in the ACEs framing overall when we're thinking about how central this should be when we're talking about this work. So appreciate questions. Thank you.

>> Helene: On the last point, differentiating on the work. It makes sense where we sit why CDC should have a focus on this. Not sure the broader world knows. In your month here, [Chuckles] how should that be perceived and? And how are you thinking about differentiating yourself be going SAMSU?

>> We want to be careful with what we define we're not. You have to have be careful. And I think the space has thought about funding and building this evidence based broadly about what the prevention looks like. How does that apply to other areas. It's an uphill battle.

I had a call with a legislator in Washington who right off the bat started talking about ACEs with me. I was pleasantly surprised that the agency has been working to build and grow. But prevention is hardest thing to show the evidence. And we got economists to tell the story better and thinking about large data is how you better tell the story. I think there's a long way to go. At CDC it's hard to move things over and think about standardization. And this helps fit the noninfectious spaces in a piece that people do understand. So we have an uphill battle. Ideas or thoughts are most welcome.

>> Helene: A comment you touched on, I think this being an area to work on other disciplines, you mentioned economic, and I think more broadly the impact, I think will help elevate CDC's role in this to help with the interdisciplinary or interjectory lens as well.

>> PANELIST: I would agree. We've worked close with public safety. And working through the drug control strategies. It's showing what we're doing vs. what we're not doing. Like suicide and ACEs, they're young programs. Overdose has only been alliance in 16. It's a community level approach than individual approach. That helps in differentiation

And talking about data, people understand that CDC is data. We won't people to think that's all we do is data. We want data to action. And now checking for syringes. And xylazine was coming out and able to the clinician calls. So looking at the novel data sources to say here's some strategies. And there was a Blue Whale game where young folks were dying. But we were able to focus on that and say here's what you can do.

>> Helene: Here's an area where there's a lot to learn from global experience.

>> DAVID FLEMING: Octavio, then Daniel, and then Josh.

>> Octavio: Thank you, this is really exciting for me as a psychiatrist for mental health. And I think CDC is spot on. This should be in your wheel house. There's a huge role you can place in the country. I think the whole country is in a mental health crisis, it's accelerating. And continuing to go down the wrong pathway. It's exciting to think about the data part but I think you can do more. To me, ACE fits very logically. It's not an outlier. This gets to prevention.

And Allison, you mentioned the suicide program at a system approach. I think that needs to go across all three. Not just two. It definitely is overdose. We do this thing here in America in our healthcare system where we have a tendency to fragment and silo. Whatever you can do to break the silos with partners and thinking of the impact of data, and see what CDC is looking at proposing.

As you were talking about and thinking about ACEs and prevention, understanding the utilization of indexes you have. Like the SVI index and immunity deprivation index. Where is the mental health crisis? We're at critical juncture, and our institutions are overwhelmed. It's one of those spots. We need to use that data.

And then tying to economics. And how economically we are not addressing these very issues. What is happening with CDC? We're have death and despair in this country, folks. And this is increasing in the percentage of the populations.

It is unfortunately impacting the communities of color, and rural areas. And now it's our veterans and those not being taken care of the country they fought for. And the list goes on and on. And those being one pay check away from homeless and leaning to the death and despair. And our health system is a systems that takes advantage of illness and death. And it's unfortunate we're not moving up to health and prevention.

Whatever we can do to connect those. It's a lot. But the CDC is very well made for that. We're made for disease control and prevention. And the CDC has helped developed and other different systems why you need to be connected to us. Why does HUD need to be at the table? Why the Department of Education?

As an example of economics, I agree of the global aspect. There's so much we can learn. Take a look how suicide is rates have been decreasing compared to other countries. We're being left behind. I'll stop there. You're on the right track, I love it.

>> PANELIST: Coming from context, I'm coming from 10 years in the role from the Chicago of Department of Health. And we are the same team and I thinking broadly of the telling the pieces. Thank you.

>> ATTENDEE: Someone said it, community engagement at the community collaborative level is going to be key. Absolutely.

>> DAVID FLEMING: Thanks, Octavio. Daniel?

>> Daniel: Thank you, I want to applaud you for prioritizing these issues. On the hierarchy of chronic diseases it's great we're elevating the issues, especially suicide.

When you talked about suicides and the 49,000 individuals who lose their lives each year to suicide. We talked about veterans and tribal, and there's another population, black children in youth in particular, as well as LGBTQ youth. What are you doing to address those two population groups as you're focusing on upstreaming interventions?

>> PANELIST: I will say, new to that space, coming from Chicago, we were seeing increasing in suicide to African Americans youth, we saw that part coming in. The LGBTQ part, I didn't get too in. But in the funded jurisdictions there's way to see where they're being left out. And we looked at what the LGBTQ works like in the field overall. I will say that. Absolutely hear you. I think also where there's, of course, overlaps to the firearm data and overlaps to the pieces here. I've given a little bit. But where we are looking to grow interest and support in a less politicized way, I think something like suicide that is landing in rural areas, there's a lot of pieces in there.

But we want to make sure that folks are developing interventions that we're funding based on the impact on the community and around the lens of that community. So thanks for that.

>> Josh: Thanks so much for that great presentation. I have a question which is on overdose, and, you know, when CDC was concerned that there was overprescribing of opioids, CDC didn't just send, you know, best practice, create your overdose prescribing guidelen out. CDC actually wrote a best practice overdose guideline that was helpful. And CDC wrote a guideline on the appropriate use of Amoxicillin and other medications.

Given what we know about drug treatment, as well as muloxon, there is an enormous gap in the ability of the medical community to provide effective treatments in addition. The medical community owned up to may be the creation of the addiction. But many people don't get offered treatment when they're hospitalized despite national guidelines that exist and legal analysis that suggest they're violating the ADA. And there's stigma in medicine that helps in life saving being offered.

So, is there a set of expectations that CDC could create for the medical community that might be helpful, like it was, to address appropriate prescribing for pain or antibiotic resistance. Whether you're open to becoming part of the voice, and a leader of the voice, to the medical community for what it needs to do to help

>> PANELIST: Yeah. I think it's an important point. This thing of where do we go beyond resources for action. Or what might be the next step. I think the point, you raise this interesting question of there is such a gap between the need and actually people getting connecting to the evidence based care. That we've seen OD2 A recipients, for example, we've seen health departments stand up for those with opioid disorder to get connected. To ensure we have a care coordinator who is ensuring the pharmacy will get that medication home. And we're able to see the practices go state wide to help folks living in rural areas who perhaps there might not be substance use providers. And for folks it's hard to navigate the system at baseline.

But we don't have enough providers. And in some stages it, health departments were funding a lot of X waivers and trying to do a lot of education. To me even though we're not funding the treatment, SAMSU is funding the treatment. I think the space to be able to link to that care and be retained in

that care. Where we know when people are released from incarceration, it's a huge risk for overdose. I think there's a space for public health to step in. --

>> ATTENDEE: I agree. I'm saying something different. CDC has specifically spoken to the community. That's what it's done on prescribing. Not on treatment at the medical community level. No one has done that in my opinion. I'm not trying to say -- CDC could. Not just fund programs that do this work, but have an emergency department and clinics to treat addiction it.

And in the past, CDC has been very influential at that level. It's a very CDC level not just to the addiction, but to medicine. And what those expectations need to be to the situation of the scorj that's killing 200,000 Americans a year.

This is the moment where there's plenty of land for that. To have a set of recommendations, the Department of Justice starting to sue jails for not providing treatment. And we did an analysis of our schools that they should be sued for not preventing deaths at 75%.

There's not an engagement in the medical to set those expectations. Anyway.

>> PANELIST: Thanks, Deb, I'll let you chime in.

>> DEB HOURY: Dr. Olson I was going to connect Allison with who might know at SAMSU that as we're doing -- as we're working with different federal agencies, Allison and I are doing meet and greets with NIH.

>> DAVID FLEMING: Great discussion. Great presentation.

>> DEB HOURY: I want to give Allison huge Kudos. She's been in this role one month, but she had big shoes to fill. She's off a phenomenal start. And so I have all my colleagues around me, which is great.

>> DAVID FLEMING: A very provocative question, I'll preface with that.

>> DEB HOURY: Allison? [Chuckles]

>> DAVID FLEMING: It makes me reflect on my comments as well, how far upstream are you willing to go in prevention? Which means structural racism because we know the impact it's having?

>> ALLISON ARWADY: I think it's central to this work. I think with the audience you can frame in different ways. But if you're talking about equity for real, you're not being true to the work of the injury center. This is a conversation I'm coming from deep blue Chicago, and this was an easy conversation and obvious link. But talking with my team understanding how you keep this central. For these issues I think it remains important to our messaging and work and patterns. Where we ensure our work remains relevant to folks across the political spectrum.

That's my opinion and that's something I know my team feels strongly about. I don't think that's provocative at all. It's central to this.

>> Coming from Texas let me to you [Chuckles]

>> ALLISON ARWADY: That's a challenge. It's an adjustment to make with my team. But I believe so strongly on the issues particular putting the need where most needed. There's ways to talk about it. But it's how you do it.

>> DAVID FLEMING: Thank you. Bottom line, it's really not fair for our children and youth here no matter what community you're looking at.

>> PANELIST: Amazing points. Please engage with your fellow OIC to talk about the structural racism.

I can not wait to see you're at one month level to see where we're going with this.

>> ALLISON ARWADY: I have a great team. Thank you for your input. I appreciate it.

>> DAVID FLEMING: One last discussion before lunch. This is Center for Forecasting and Outbreak Analytics.

>> DYLAN GEORGE: Thank you, for those of you that don't know me, I'm Dylan George e director and a handful of the team is with me as well. If you aren't familiar with the Center for Forecasting and Outbreak Analytics we're new at the CDC. We're at the early stages of building the tools, teams, and partnerships going forward. First slide, please.

Thank you.

Very grateful for the opportunity to give you an update what we're doing. In 2023, the Center for Forecasting and Outbreak Analytics we had a strategy plan, and outlining our long-term mission, vision, and goals. Our vision is to empower people to save lives and prevent community threats. Our secret sauce for that mission is to harness cutting-edge analytics to improve responses for public health emergencies.

We were born out of the pandemic and born that we need to use data and analytics much more effectively to keep Americans safe in the time of crisis.

Just in our second year of operations, we have already made significant progress in driving technical and analytical innovations. And we're trying to created a future where infectious disease forecasting is as common at weather forecasting.

For industry data to creating modeling for influenza CFF an is build our national capability to use advanced analytics in a time of crisis. Next slide, please.

To fulfill our mission and become the trusted source of outbreak forecasting and analytics, we need good people and sustained support.

From this slide, we started November 2022 -- 2021, excuse me. We had a critical investment in the public health and national security infrastructure. And we continue to build a world class organization.

It's critical we maintain sustained funding moving forward for our innovative work. We started multiple funding in the first year. $200 million from the American Rescue Plan. Congress authorized us with $50 million. And about this time last year, the President came out and requested

$100 million in our base funding in appropriations. And this is the level of funding we will anticipate for our capabilities going forward.

CFA success relies on good people. We are working to attract and obtain a creative and effective workforce. I refer to the team at CFA "crazy good". They are amazing. We have attracted people in industry left higher paying jobs because that they believe in the mission. And we have attracted that are forgone tenure track positions that we were in would have gotten good academic positions. It's a crazy good team.

When we launched in 2021, we had five people. Six months later, eight people. And year left a 25. Now we're 70 people. That's halfway where we are need to be full operational but we've made good strides.

Our work can be summed up we use better data for better analytical tools for our impact going forward.

Better data and analytics, better models and forecast start with better data it. We have seen that CFA relies on high quality data from the data initiative. My colleague has briefed now in the past with the data modernization initiative in the public health strategy. It's critical we build on the efforts and successes they have.

Incorporating the new sources of data in the last year have improved the models to make better predictions of disease out breaks than before existed.

An example, waste water data is a new and transformative data that is exciting within CFA generally. We're reaching the height of anticipation -- and through the collaboration of colleagues, ESID and global health center, we have use waste water and syndromic data to develop state level forecast of COVID. We have more accurate forecast. This makes complete sense. It's a leading indicator of what's going on in circulation of the community. And help with peeks with troughs.

And we're making advances how we use data and improve our forecasting capabilities broadly. CFA has factored the code by the response team. We have made it much more robust, portable, reproducible and efficient. The models used for COVID-19 forecasting run ten times faster. So that future partners can respond to out breaks more efficiently.

And these methodologies solve key problems with understanding on our hospital systems. Better data and accurate models lead to better information to use to keep families safe.

And to translate these forecast models for analytics across the nation for decision making, we have the support at the local level.

And the respiratory season outlook. In 2023, we released the respiratory outlook for how to prepare for the season. And it was for COVID-19, influenza, and RSV. And predicted a similar amount of total hospitalizes for 2023 as 2022. We shared to media outlooks. And Adrian did a brilliant job to make sure we're connecting with our state, tribal, local, and territorial partners to move forward.

And this equipped them to know what to expect through the year. And to have targeted conversation with their hospitals. And if they were ready, great. If not, see how to do it better.

Influenza modelling was another advance. And we submitted weekly forecasters into the influenza forecasting challenge. This was the first time CDC ever released forecasting results. You may say, we've seen the results on the CDC for a long time. Those were submitted by academics or private partner into CDC. This is the first time within CDC we have generated those on our own.

This is a major milestone and major capability. Jason who leads the team has done a brilliant job Galvanizing how we move forward in that space.

Outbreak monitoring has been ongoing. We've had to chew gum and walk at the same time. We are growing and trying to walk at the same time. We have a range of those like COVID, and handful of others in helping out. Our ongoing work and sharing analytical tools has given more timely information during response times.

We're proud of being able tool help out in a more robust way. The increased collaboration. As CFA continues to grow as an organization, we are helping to develop, test, implementing and share data models forecast and analytics.

We have colead a combined force to lead.

(Cross talk).

[Talking in the background]

>> DAVID FLEMING: I'm sorry, is that coming through the -- could the folks in Zoom make sure they're muted? We're getting back ground noise.

>> PANELIST: We have led with the response task force. We were helping to lead that work. To not beg across the centers anymore. And then collaboration, Aydian in the room did a beautiful job moving outside the United States. CFA developed new partnerships with tools. And we have the public health of Canada to help generate better risk assessments and strategies and tools.

The reason why is this will enable us to talk to our state and local health departments to Galvanize a better approach going forward.

Next slide, a couple of key things we have done going forward. This is the RT estimate of growth of a particular outbreak. How many infectious individuals will be generated from one infectious person. This is how a measure of disease spreads efficiently within the community.

One of the things that's been exciting we've been doing in the work is we've celebrated another first. Back in December. We released the first COVID and influenza. The I.T. has been in this user friendly coded maps that are updated on a weekly basis. One thing really useful about this on as a personal note, when I was talking with members of my own family, I could point to them to maps of what is the circulation in your particular location, what is the status of Covid, influenza in your particular location and then I could point to these maps and say, what are you going to anticipate in the next handful of days to weeks in terms of a growth or decline in the Covid or influenza in your area. That helped them understand what was the risk that they were going to be confronting and assess what was their level of behavior that they wanted to change and how they would go forward. So it was a tool that was helpful for me in talking to my family. I'm very confident as we aggressively make this much more available and understood, it will be a tool for many more families across the United

States. Next slide, please. The other thing I wanted to do a little more deep dive is this thing as insight net. To speed up innovation of progress on new tools for state and local public health, cfa launched an insight net.

This is the first modelling network of insight net represents the largest government investment in modelling public health infrastructure to date. 13 performers and awardees represent public, private and academic sectors. They are bucketed into three big groups.

First group is the innovators, they're coming up with new analytics, new models and testing out new data.

Second group is what we refer to as the integrators, the ones working with health departments to validate that it's the new analytics are fit for purpose, that are going to help analyze or make decisions bigger, faster, stronger in some way.

The last group are the implementers. It's not a chicken in every pot kind of model. If we want to figure out how to make these capabilities much more accessible, usable and understood by as many jurisdictions as possible, they're the ones that are tasked with scaling those capabilities.

So coming up with new innovations, testing them with health departments, scaling them across jurisdiction $ what we're trying to accomplish with insight net going forward. This is a huge step forward in making sure that we are workong closely with our state and local partners to build capabilities at that level going forward because we know in our federal system, that's where a lot of decisions and authorities lie and that's where we want to work very closely going forward. Next slide, please. Now, we have a handful of goals and a handful of things that we want to accomplish across the buckets going forward. We continue to work towards our goals in using even better data and creating better tools and expanding our access and availability to the partners. Better data, cfa will use new data to improve accuracy and speed. We'll continue working on waste water data, improving those capabilities where we also are looking at as I understand -- syndromic date arcs looking at data to help us improve the forecast, anticipate how the hospital systems are working going forward. And we're very excited about some of the successes that are moving forward in that space. Better tools is going to be a key part of our goal to advance the system, the tools and the products and we will continue to make our primary awardees get stood up, working effectively as a network of networks but also working close well other centers of excellence across CDC. By focusing on rapid innovation and implementation and systems integration, we will empower CDC and our collaborators to develop cutting edge analytics effectively and to deploy them in the most effective way. In 2024, one of our top priorities is going to be working very closely with state, local, territorial and tribal groups. We want to make progress in that space. This includes enabling new modelling tool kits designed specifically for state and local jurisdictions. We also want to expand access to our advanced cloud enabled virtual analyst platform that modelers at local and national and even international levels can work in a collaborative way together.

This will allow us to collaborate model, file and co-chair in a much more rapid fashion especially during an outbreak. So finally, what I would like to end with, though, too, is that 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. We will continue to work towards a future modelling forecasting, and advanced analytical tools are the -- at the ready for decision makers and indeed for all Americans.

And we want to make this a reality going forward. The reason that I left the private sector to come to CDC is because I do believe we are at a transformative moment in history.

There's a clear need to use data more effectively. There are advanced technologies that we can employ within public health being used Bradley and effectively in the private sector. And there's a need to make sure that we don't have happen what happened over the pandemic again and so the reason that I left the private sector is because I think we can make a significant advance in these capabilities going forward and with that, I will stop and take any of the questions you might have. Thank you.

>> Thank you for that passionate presentation. Appreciate it.

Start with Jill and then Julie.

>> OK. I want to make a couple of points. First of all, congratulations. Fantastic, exciting. It seems like you're building something that is not disease specific which has been a real challenge for the CDC with these moneys so you're building the infrastructure which is lovely and if we can do that in other areas, then that would be great. I also would like to congratulate you on your partnerships. Really, really good. Now, here's the challenge that I see. As you sit in a transformative time in using new technology, we're also at a transformative time in diagnostics. New technology, the public has an expectation of home use. The home use tests are not delivering data. Now, how can we incentivize manufacturers to develop a system that is non identifying so, you know, I look at zip code, positive and negative so that you get -- and that that information is given to the regional health department so that says, hey, there's something going on here in combination with data from pharmacies maybe, in products coming off the shelf. So how do we do that?

>> Yeah. Thank you so much for the question and I think it's --

we all saw the world we want to be in going forward. This is a long-term trend.

It was accelerated by the pandemic. Health care delivery is moving from the hospital to the home. And in addition, it's like over the pandemic, my GP, he actually retired at the end of the pandemic so when I was looking for a new one, I actually found one that was fully tele health and because it was really exciting to see, it's like, well, how well will this work? The fun thing that --

>> Can I interrupt you for just a second? We may lose our computer because of a forced restart.

>> Oh, no.

>> I just want to alert the folks on zoom, you may go down.

If we do, with your permission we're going to reconvene at the top of the hour rather than at ten after the hour for the next presentation. Hopefully we'll continue to see you during this presentation but if not, that's what is happening.

>> It's not you, it's us. But yeah. Moving health care delivery from home to hospital is a big trend and also like the telehealth, the box of electronic goodies they sent me to be able to do sensors across was inspiring to see how we do but I completely agree with you, from home diagnostics and wearables in other sorts of bio sensors that are going to be proliferating the next five to ten years, it's going to fragment the system even more so in how we actually aggregate the data coming forward.

It's going to be a very challenging environment to work in. I don't know the answer there but I'm right there with you in trying to think through how we would actually deal with those kinds of issues.

>> and so it seems to me that if we can do it in stages where people get used to one level of information, get comfortable with that, nobody is coming to get me, you know, and then have the next conversation. I can't see doing it all at once but we're going to be missing a huge amount of data if we don't do something.

>> completely agree. 100%.

>> Thank you so much for your presentation and the update.

It's amazing progress that you've made in a very short period of time. I have a couple of questions for you. One of the things you said early on was how you have been able to recruit and hire staff from industry from academics throughout -- who would have gotten higher salaries just because of the commitment to the mission and the mission of the organization of your work. And I'm curious, we heard from state and local and others within the CDC agency saying they're unable to do that so I'm curious why it is that you think you can be successful and others have not been able to do that.

>> Yeah. No. Well, of course, just boyish term. No. No.

Seriously, though. I do think that the mission is really resonate with a handful of people that are working in more tech related sorts of spaces.

And there's a direct analogy of like moving things over but also there's been 20, 25 years of kind of work in this space of trying to use analytics, trying to use modelling and trying to use different sorts offal GAfal GA --

algorithms moving forward. One of the things that really helped us out, too, is that people are seeing how serious we were about actually building this organization and part of it, too, some people are attracted to building a whole new organization and that interpaled the government startup that's going to be slightly hard to replicate in other ways. And then the last thing I would say is once people started seeing the quality of people that --

once we got that initial nucleus, we started seeing a snow ball effect. And then I think that's part of it. So I don't know if there's a lot of generalities that can be pulled off of that but I'll think more about that. Yeah.

>> I think that's great. There's others that could benefit from using it if there are things that are replicable.

>> One thing that I will say, too, is that Congress gave us the authority to do direct hire.

That was a huge benefit. We hired ten people like that. That was a huge benefit, number one.

Another thing, too, is having ability to hire remotely really enables us to hire quality people that are struggling with kind of the two body problem in an academic sense so it's -- you know, so it's -- that has been, both of those things have enabled us to hire quality people in a big way.

>> So those things could be replicable.

>> Yes.

>> I have I have a question, too, that could be relatable. In terms of reference that we have now, it's very specific about us helping form the modernization of trying to -- as you're trying to streamline the data. Sources that are coming in. And I'm listening to you and hearing all these data sources and I'm thinking, oh, my head splitting because part of the goal is to streamline and simplify. You're talking about other novel data sources and I'm just wondering how you're thinking about that as we move forward. I think when Dr. Cohen has described is a really needs to be using --

supporting the systems that benefit the whole agency and the nation and not doing things --

so I'm curious how you're engaging to make sure that's not adding additional --

>> Jen and I talk repeatedly multiple times a day and we're very -- we work very close with the office of public health data, surveillance and technology team, very, very close with them on trying to make sure we're coordinating and connected. I think that I often say it's like, you know, I think what's going to enable us to be successful is the degree to which we can work with state and local jurisdictions and effectively work with them and provide them tools that are successful. Also the data -- the public health data strategy has to succeed for us to succeed.

It's critically important. The degree to which they succeed means the degree to which they will succeed going forward. Now, we'll always be able to extract more information out of data that are existing but more data is more better. So it's pretty much what it comes down to. But I also, going back to Jill's comment, too, it's like I do think the next five to ten years, we're going to see a much more fragmented data system within health care. Unless there's something like what we saw, I think there was a glimmer of hope here, too, what you saw with apple and Google working on exposure notification, regardless of how you feel about exposure notification, there was a huge success in that, that apple and Google created infrastructure at the enterprise level to make that even possible that we could even conceive of talking about it. We need to find ways to actually aggregate on a level that we haven't seen before and it goes against business models in trying to monitorize data in different capacities so it's going to be, I think, a hard slog for the next while to try to take advantage of the things that Jill was talking about. Yeah.

>> So that was going to be one of my questions is how are you thinking about working with the private sector and what would help to build those kinds of partnerships. What would you need to make that actually work?

>> Yeah. As I mention would, I was recruited out of the private sector to help build this organization. Our chief technology officer is Eric. He was the chief technology officer from mozilla. He came over to build what we're building so we've had some success in working with the private sector to build things going forward. I completely agree with you. We need to think about how on TO use different mechanisms to pull in private sector capabilities beyond just the standard sort of contractors going forward in different capacities so we've been looking at a handful of different authorities that we could look at other transactional authorities and small business innovative research.

>> I'm thinking less about the development of technologies but more about how to harness some things we're talking about so the fragmentation, thinking about up front how to reduce that fragmentation.

>> Yeah. That's a great question. Like I said, in the beginning of the pandemic, I was working in the private sector and we had a lot of conversations with apple and Google and a handful of other groups that were trying to build that infrastructure that would allow us to do things but we do need to do more in that space.

>> I'm just wondering whether there's, you know, a broader strategy that needs to be put into place where there's actually at a higher -- at a higher government level, perhaps even departmental level thinking about, you know, making some of those very explicit agreements.

The other would just -- this is incredibly inspiring and as I think about, you know, part of what we're all interested in is how do we continue to build CDC's credibility and I think this gives a lot of credibility for people who didn't have that kind of capability. So communication strategy, how are you getting this out beyond state and local and territorial, tribal health authorities but really thinking about, how do we use this beyond just the impact on disease prevention to really think about bringing and building that kind of trust in public health science?

>> Thank you for the compliment and also for the challenge because we completely agree with you. It's like -- in my ill spent youth, I worked at the White House in the office of science and technology policy and where we were thinking a lot about how to develop this capability and the director of the national weather service at the time, he told me this really great story about how they had these beautiful models for tornados and other severe weather but they had terrible ways of communicating the modelling results so the point that some of their risk communications were actually putting people in harm's way during tornados and that sort of thing. The message that Louie was trying to teach me more than anything is like you can have the best model in the world that will tell you exactly what's going to happen. If you can't get people to understand it and communicate it in such a way that it actually elicits the behavior that will protect them, then it doesn't matter how good your model is. That's one of the reasons why we have spent at least a third of our effort trying to figure out how to communicate the results more effectively. And so I'm very much aligned with you in terms of figuring out how to communicate those results much more effectively. Exactly. Yeah.

>> Two more quick questions.

First from Rhonda and then from Jill.

>> Mine is going to be really, really quick. Dr. George, I don't know if you ever heard of me but now that I've heard of you, I think I like/love you. I love the body of work that you're addressing and how you're doing it. When you were talking about, you know, bringing private industry in, the other part of the private industry are the health care providers and health care payers and I wish I could be there to hold your hand but I would like to make sure that you know you're going to have to talk to them and you're going to have to bring in some early adapters to kind of help you work with it. Otherwise, all of the genius, all of the fantastic work that you're able to do may not translate into a clinician, health benefits program, et cetera, being able to address what is in the data.

So at some point there has to be like a bridge.

I know you know it but I'm here to ask to make sure that you figure out when and how you do it but in the meantime, please don't lose your focus.

>> Yeah. Yeah.

>> That's -- you've been at the White House, you've been in politics. You know the people will try to use things that you ever built for other purposes.

Please don't lose the focus because this is what we really need right now is what you've got.

>> Thank you for your comments even though they made me blush a lot. I really appreciate that.

One things I wanted to highlight with you as well, too, over the last two years we've been working with the university of Utah and the university of Utah hospitals and intermountain hospital system and one of the things that was really exciting about what they developed is during the pandemic, they were able to use their electronic health record to give situational awareness what was happening in the hospital. They were working with the universe TOIT generate folk casts based on the data to help them understand what was going to be happening the next handful of weeks in the hospital. They use that combination of both of that information in a couple of different ways. They could figure out absenteeism of their clinical staff, their nurses and their docs, how much they would have to backfill. They would also look at how many heads and beds they would have from Covid and then that determined how much -- how many electric procedures they could do as well. Then they also used it for scarce resources in the early part of the pandemic. This was an early example how we were trying to work with health care to make these kind of really granular decisions. We are working with them. They're one of the members, you know, one of the awardees in our network and we want to see if we can scale that but would love to work with you to get feedback how we might scale that more effectively.

Yeah.

>> You're on mute, Rhonda.

>> It's probably good you're on mute right now because I would probably blush.

>> No, no, no. I've been told not to tell you that I love you.

But I've already said it so you already know it. But what I wanted to say is when you're working with health care, you're working with the providers, work a little bit with the planners, too. They do have data that can be used to give you sentinel information, right? Particularly pharmacy data, anti-virals, right? When we watch the anti-viral prescription use go up in some counties in South Georgia or the west coast of Florida, we can tell the physicians are seeing something.

Something is going on and it's picking up but that's another thing to be added to the arsenal of information that you have.

But great job and thank you.

>> Thank, Rhonda.

>> I promise I'll be quick. So we've got a communication issue.

We've got a manufacturer's incentive issue. OK.

Manufacturer's incentive, think about Redicks. They seem to be moving beyond infectious diseases. I know they had a maternal health challenge and maybe for a disease or disease situation that's non threatening to the individual, so, you know, pick a target and if we could incentive using those programs, manufacturers in a particular area that's less individually threatening, is that a way to go.

>> Yeah. No. I think so. I think there's something there and it would be great to talk with you more about that particular proposal. I know the diagnostics bases is challenging given the ring LA -- regulatory requirements going through the business and the business model is challenging, too, from the standpoint of the return on investment is not what it is for therapeutics or vaccines so it is a tough, tough space to work in but I would love to follow up with you on any of those thoughts. Yeah.

>> Thanks very much, folks.

We're going to break for lunch.

We've avoided the computer shutdown during the session and so we'll convene at the top of the hour. Appreciate you being here.

>> And lunches are next door.

>> For those of you I haven't met, I'm the chief of staff here at CDC. Coming up on my one-year answer -- anniversary which is kind of mind blowing. One of the key roles that I was charged with when I started a year ago was the continued implementation of CDC moving forward and all of the tremendous effort that we had started over the summer and fall of 2022. I think this group was able to hear from Mary and Jim late in 2022 about the work that they had done to bring folks together internally in CDC and external partners to really take a look at those lessons learned from Covid and help us get set up for the public health agency of the future that we really want to be and need to be. Part of that work was creating priority action teams that were made up from folks all over the agencies who put forward recommendations on discreet actions for CDC to take and implement over the course of a couple of years. Right now we're in the middle of that implementation process so if you go to the next slide, they're telling me I need to say next slides. As a reminder, these are the seven main core areas for improvement plus the integrating health equity which is, as Mandy was saying, embedded across all the areas as well as being called out on its own so we ended up with about 160 discreet actions that are bucketed in all of these areas and I'm really excited to tell you that right now, we're -- we've completed more than 75% of those actions with the remaining 25 on track to be completed over the course of this next year. Some of the action, and I'll talk specifically through some of the critical areas but we have things that were, you know, sort of one and done pieces of, you know, like changes to a specific policy or making sure that the right communications people were involved in the right response activities. You know, those sorts of changes internally. We also have a lot of actions that are requiring ongoing implementation efforts so we are monitoring the implementation of those actions, continuing toity rate as appropriate and then just as Mandy discussed this morning, really looking at the next chapter of moving forward so be that strong foundational base of operational excellence across CDC that will help us really succeed in

the priority areas that we have identified as an agency. The other component of moving forward was the --

some of the reorganization work that happened a year ago as well where we were elevating offices, creating more cross cutting work to try to break down some silos across centers so happy to talk more about that but I think you have heard about that in previous meetings as well. So if you go to the next slide, I just want to sort of tick through some of the highlights of the work so you can see where moving forward has been demonstrating a value add to work that we're doing across the agency. So one of the places that really came to light through the process that Mary and Jim and others worked through was to make sure that our -- we're getting science out faster. This is something that Deb and team have worked very closely on and with our team of office of science and the clearance process is a place where we're really seeing the improvement here. Our process now has allowed us to cut review times in half and we have improved -- we have 120% CDC-wide improvement in our clearance rate so we're really proud of this and then I think the other place that you're seeing this is other ways that we're communicating science so as part of our respiratory virus response this fall, we were posting weekly updates on our website of here is what we know about the latest variant or here is the latest update about vaccination, here is what we're seeing in the data so really trying to use all of the tools that we have available to us to communicate the science that we have. I know that you all have been closely involved in the work around improving our lab capacity, quality and safety and I really want to thank the work that this committee had done in that space that those recommendations from this group were what was rolled into the moving forward work as our action so this is a place where we still have some ongoing actions that need to be implemented because we want to get this right and we need everybody to come along so we're really making sure we're taking time to do that but one thing that has been implemented is the electronic quality management system that's part of the broader laboratory quality plan so we are happy to have this piloting right now the software to manage the system for a phased rollout across the agency in 2024.

>> Let me interrupt you for a moment. I see that Josh has raised his hand. I'm not sure if he is on or is he trying to get in? He raised his hand. I was wondering if he had the question about the lab piece. OK. Never mind.

>> Josh, just raise your hand again if you need anything. And then the third place here, last fall we rolled out our public health guidance framework.

Again, trying to get at that recommendation of how do we translate our science into implementable, understandable and meaningful public health guidance. I know Mandy talked a little bit about morning about how that framework is being applied and working well in many of our areas today. Some areas we have some work to do but it definitely is the direction that this agency is going to take going forward. Can you go to the next slide, so clean slate, another area that Mandy mentioned this morning, again, our website has hundreds of thousands of webpages on it and we have been working really hard to go through every single one of those to make sure that the information that we have available to the public is useful and meaningful and appropriate for that audience.

We are relaunching our website here this spring and so we'll keep you all posted as those websites get updated but we're expecting that we'll have a reduction of at least 64% of our current content as part of this process. And to not raise any alarms, we are archiving everything so we will still have

everything available and so we can go find anything that we would need but at least we expect that this will really enhance the usability of our website for a broad public.

We're also really excited, you know, the work force piece of moving forward is a critical component and internally, we have launched CDC ready which is a platform that we are using to organize ourselves for a response. So this is really a cool tool. Every single person at CDC is able to create a profile within the CDC ready system so when we have a response that we need to be deployed for, we're able to go find the right expertise and skills from the right places to help put them at the forefront of the response and then the platform also allows us to --

for those participating in the response, to have easy access to the data, the reports, everything that has come before so it really reduces the administrative burden of joining a response so we're really excited about that as well. And then the last one on this, I know that les was here talking with you all today but really appreciate her leadership in thinking through our public health infrastructure grant.

This is the way that we are trying to build the public health system that we need across the country, not just here at CDC, and making sure that our grant programs are aligned with not only the work force needs that we have but the goals that we have around equity in our work force as well. Next slide, I know you have also heard often from Jen so modernizing data is a huge effort as part of moving forward. I know you all are very familiar with our electronic case reporting and how we did not have it before and we are really working closely with the team to improve that and now we have more than 28,000 facilities across all the states using electronic case reporting so that really helps our data efforteds. I also am really proud of the team sort of connected to this area plus the communicating science faster.

You know, you have seen that we made some improvements to like our waste water VIZualization dashboards so how do we harvest the information and get it out quickly and in eye usable format. And then finally, one of the other big components of moving forward is how we are across the agency creating and building results based partnerships. So the best example that we have for this is how we are using the collaborative initiatives that I know Charlene came and talk to you about last year and then you saw again reflected in

Dr. Cohen's priorities she talked about today. This has been in line for us for awhile now. But we have specific projects that we have identified in these three bucket areas that are targeted at results based partnerships so how is CDC bringing our expertise and resources to the table in these areas and then how are we measuring success and implementing what we've learned from that? So we're really excited about using this as part of this next phase of moving forward to really demonstrate how partnerships are essential to all of the work we do across moving forward. And then our last slide here just want to take a snap shot of where we are in the time line for moving forward. So we are, as you can see, you know, squarely in this implementation phase and working as I mentioned to make sure that we're tracking and monitoring either the use of new processes that we've put in place, you know, making sure that we're having conversations with our cio's about how things are going so if there's anything else we need to ireate on or continue to update that we do that and then really think through how do we build on the successes of moving forward to make that one CDC enterprise-wide foundation as strong as it can so whatever the challenge is that gets thrown at CDC, we have that really strong base to launch from. And I think that that's really -- that was really the point of moving forward, right? Of like how do we break down some of those silos,

make sure we have those strong connective tissue across the cio's so whatever it is that we need to do next, we're prepared to do. I'm happy to answer any questions. Jimmy who has been with us here today has been a huge supporter and help in implementing all of this and that we really do have leaders from across the agency who have been in, you know, elbow deep with us as we have been trying to get through these actions.

But the biggest challenge that I think you heard this a little bit from Mandy this morning, too, some of this requires massive shifts to the way that the agency works together and so these actions are discreet actions, they are important and needed to happen but we can't take our foot off the gas and we need to continue that now to demonstrate how these changes we've made are a value add in helping the agency as we move forward. It's impossible to talk about this without saying move forward. It's very difficult. So maybe I'll stop there and see if you have questions. What else can I share?

>> Sounds like the initiative was well named then. And can we just remove the slides so that I can see who in our virtual audience is there? Josh had connected, right?

>> I'm here. I'm here. Can you see me, David?

>> I cannot see you, no. There you are. All right. All right.

>> Well, now that you've noticed me, let me just say the moving forward work is really fantastic. It's really hard to do internal projects like this when there's so many demands from the outside world happening at the same time. But it's just incredibly important for, you know, fixing things that have been problems before and setting a strong, you know, platform for doing all kinds of things in the future. So really, really appreciate that as I know how hard it is to do that kind of work.

>> Well said. Joe, is your card up or is that from before lunch?

OK.

>> One thing that the lab work group raised when we did the evaluation in our first project was the structure of the ims in emergencies and that was --

didn't seem smooth at best during Covid. Now we're working towards one CDC. I assume you'll still keep the graduated response but how is the ims going to be structured?

>> yeah. That's a great flag and is something that we are actively looking at right now related to the graduated response framework because it does -- in some ways box us in, right? As you know when it gets implemented. So this year, just as an example, we -- when we came out of the public health emergency last spring, coming into this fall and winter respiratory system, we were thinking how do we organize ourselves when we're not in an emergency but we have an issue where we need all hands on deck and across agency systems. So what ended up happening, and what I think worked well, though I know we need to make some tweaks as we think about it going forward is that ncird set up a respiratory virus response group and that included all of our enterprise-wide functions so data, lab, science, comms, OCOO, operations folks, office of health equity plus the blue team, the Covid team, the rsv team plus les' team, all of senior -- you know, everyone was really invited to sit at the table and participate. And it wasn't a formal response structure, like there were pieces of it that mirrored it like we ended up setting up a channel for the comms folks to make sure everybody

was getting the communications materials. We had regular meetings that went through and then here's the issue so learning some of those lessons. But sort of without as much of the formal structure of an ims system. And I think that worked well for us with the one caveat that this is an agency that when something says response in the title, they feel a certain way about it, right?

And you behave a certain way so we're going to work through some of that going forward but that all hands on deck on something that wasn't technically an emergency was somewhat of a new feeling for folks. And I think we learned a lot of good lessons there. That's all to say we're trying to think through now the graduated response framework and see if we can figure out, yeah, how we make that fit. You know, and similarly thinking about the mpox response and now thinking about the next mpox response.

Like what's the right way to lean in, make sure we're organized and prepared and leaning in so we're ready should we need to go into that emergency phase in a way that is not -- everybody is not constantly in an emergency response. So it's a tough balance. I don't know if you want to say anything else about that.

>> no. I mean, I agree with what Kate said. People react to the word response as well, you know, because we've heard from some of our staff that get ptsd talking about response because they've been in response. Be prepared. I think that's what trying is people have enough awareness but more programmatic in nature where we can.

>> The other thing is people at the executive level of the ims need to know everything. There's an expectation that some things will go wrong but you need to know about it so that you can do something about it and that's --

you know, people take pride in their work and don't want to admit that there's a problem.

>> I think we learned a lot, though.

>> I think that that also requires leadership knowing when you hear a thing, everything can't always be a crisis, too. I think it's something we're working on. Multi directionally.

>> Thank you so much for the update. It's incredible progress that you've made on this especially given there's a transition moving forward and you have a change in leadership and the work is impressive. I have a comment and a question to build on what Jill was talking about. I think Mandy described the siloing that's happened in the organization when I hear about the goal, one CDC, to me it's like breaking down the silos, not just in a crisis or in a response but just the baseline and I think silos actually break down more easily in the crisis. The challenge with the siloing is much greater than baseline. And it was interesting when Deb and Allison were talking about mental health work, I thought it was interesting that you clearly defined your goal. Deb talked about the agency-wide priority and then Allison talked about the center's priorities. And I'm wondering, Deb can't do that for all issues within CDC. Are there people like that thinking across the organization for the different priorities? I think that is having a responsible person who has that information can really help to break down some of the siloing that occurs.

Just curious if that's in place or if you're thinking about doing it.

>> yeah. No. That is a great question and I will say kudos to, you know, Dr. Cohen for coming in in the middle of this and, you know, really picking up the ball and running with it.

She was very clear on her first day that she saw the direction of moving forward and wanted to make sure that it was continuing under her watch and I think you can see how it is evolving in a really healthy and productive way as we are continuing to go through this that, you know, thank goodness Dr. Walensky got this going because that was the hard part of identifying the problems and so we've just been, I think, lucky with our leadership that we've been able to keep this going. You're exactly right. We can't just work together in a crisis, that we have to work together always and so what Mandy didn't get into the details on around her priority areas today but the way that that is being executed is that for that readiness and response bucket, for instance, there is this afternoon a meeting where we have a leadership meeting on the readiness and response priority area and every cio director is invited to that or, you know, they can -- it's a lot of meetings so they can send a deputy so there are critical people who have been identified as leads on different components of that but everybody is at the table and has visibility and transparency on to what's happening in that area and then also you're at the table and so you can get tasked with part of the work as needed and as appropriate. And that's the way that that has been set up for all of those priority areas. So, you know, we are -- and it gets even more granular in those collaborative initiative issues, too, right? We're bringing in folks from outside CDC to sit at that table but you're right.

The way that Mandy is really thinking about those priority areas is that everybody should be at least read in and knowing where we're going and potentially have a thing they need to do in those areas. So Mandy for sure is the one person and then I think you know that all of our leadership in the iod and across the centers are thinking that way, too.

>> one quick question on what you were just talking about.

These things work best and maybe work only if there are dedicated staff beyond just cio people who show up that can actually serve as the momentum to continue. Are there dedicated staff? Have they found dedicated staff?

>> Yes. This is another place where, you know, Dr. Walensky was able to find us resources when we got this project kicked off. In our office of chief of staff, besides this being part of my performance plan as I'm accountable for this, you know, we have others on my team and helping with that and then we also have other staff who are helping us with the project management pieces of it and some of the other communications as well.

>> Maybe the longer, maybe unfair question because we've heard this morning that CDC can have only so many priorities. On your results based partnership, there are a couple of areas that I would highlight, health equity, equity and climate where even within our recommendations for equity, we said CDC needs to engage in partnership beyond HHS with other federal agency in order to make that happen and certainly that's true for climate as well. I'm wondering if you can talk with us at all about the extent to which you're able to find the resources to engage with the department of transportation and HUD and usda and the other non-HHS agencies that are critical for your success in those areas.

>> yeah. I would say that some places we have a head start more than others. You know, during Covid especially, there were a lot of engagements across the inner agency because things that we were doing at CDC had an impact, you know, across so there were good connections build and then I would say also when it comes to like usda that we have a lot of different parts of our cio's are engaged there.

But certainly I think there's an opportunity at a leadership level to sort of deepen that work. You know, so we have sort of the food work happening in one place and then sort of the animal health, one health work happening in another place but I think there's definitely opportunity there. And then out of Covid, you know, I think we have a great relationship with our department of Ed partners so we talked a little bit about some of the school based mental health work that's happening but then there's a lot of other school based public health issues that we have good connections with but it's a good question and a go ahead place for us to continue to move forward. I do think on some of the health, we have some good opportunities with our noaa partners and like thinking on the weather side that that's a really strong relationship that we're looking to capitalize on, really, with that work this spring. And I think we also have more to do within HHS as well.

On the behavioral health side, I think there's strong relationships but this bucket of work every integrating public health and health care, you know, that is a place where I think we have a lot of ideas and ways that we can better connect with our cms and colleagues.

>> Excellent. Don't forget the dot.

>> yes. I did write all of them down.

>> OBLG David's comment, I was having MRASH flashbacks of my time in Chicago and the way we got our foot in the door, we had the data and that was valued and wanted and so while it may not have been what we were wanting to get out of the agency, it was --

[Inaudible]

that's something that seems inevitable.

[Inaudible]

as we talk about structural inequities that lead to poor health outcomes, engaging with the other agency $ critically important. They play such a major role in terms of health.

>> Thanks so much for taking time today. We really appreciate it and just want to echo the appreciation for the remarkable progress you've been able to make. It's spectacular.

>> We're getting there and I'm excited to come back next year and tell you we've checked all the boxes off and that we're really moving things forward at the baseline as part of one CDC and thank you.

>> Maybe later this year.

>> I also want to thank you for doing this work with us. It's really, really helpful and important to have partners and champions and sometimes critics sitting at the table with us. We really, really appreciate it so thank you so much.

>> Can I just jump in there and say you need to advertise what you're doing? We wrote a scientific America on your progress. It's good progress. We did say what else you needed to do but I think, you know, tell the world about what you're doing, really. You're making great progress.

>> I'll take that back to the comms team. Thank you all.

>> Thanks a lot. OK. We're going to move forward and next on the agenda is this -- we are working towards as early as possible retirement. We'll see how we do on that but we are going to receive a health equity update and leandris, you're on for talking with us about some of the work in progress.

>> Thank you so much, David.

Good afternoon, everyone. First of all, I would like to acknowledge the acd for their leadership and contributions in laying out recommendations to enhance and AK is heing rate CDC's efforts to achieve health equity across this broad portfolio of public health, science and programs. For any of our new members, I want to give a quick summary of the process.

The now sunset health equity work group of the acb put tasks forward. They were then adopted as recommendations by the acd and subsequently acknowledged by the secretary of the department of health and human services.

Office of health equity was then tasked with leading the implementation of the recommendations in close collaboration with the national centers institute and offices of CDC. During the last acd meeting in November, I provided a brief overview of core which is CDC's health equity science and intervention strategy and I also described some AKs that were underway to incorporate the acd's recommend ages into CDC science programs and policies and today, I will discuss our continued progress and accomplishments and reflect on the work we made. If we could go to the next slide, please. The office of health equity was launched in 2023. Let me say that it build upon the agency's 35 years of a focus on certainly racial and ethnic minority health and the office 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 health outcomes. This work is done in collaboration with the national center's institute across the agency. In standing up the office over the last year, we talked about five strategic imperatives as part of our much broader strategic plan, highlighting priority goals and major activities through the 2024 calendar year. We're using this plan to pursue our mission and guide our day-to-day work to advance health equity so the first imperative is strategy. So in a commitment to health equity, it's going to be successful, we must institutionalize its principles and practices and align agency-wide initiatives to accelerate progress toward achieving health equity. And toward this end, we have developed an office-wide strategic plan that's one of actually the moving forward deliverables that the -- that our office submitted actually last year, the end of the year.

And also including a multi year road map metrics that INT grit health equity, social and structural determinants of health and diversity, equity, inclusion, accessibility and belonging. And this is the foundation for creating long-term change within CDC to advance health equity. If you look across the additional four strategic imperatives focused on funding, partnerships, the public health work force and science and interventions, we are operationalizing the recommendations that were

approved by the acd. We have intentionally aligned the activities within these imperatives with the acd health equity recommendations and I will highlight some of our progress in the next few slides.

Next slide. So consistent with task area one, CDC recognizes community engagement as the cornerstone of good public health practice. And our partnerships' imperative is focused on increasing community engagement with populations that experience health disparities and health inequities. For more than a decade now, the office of health equity has collaborated with public health organizations such as the national association of state offices of minority health to promote health equity.

And last year, we 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 public health alliance. This alliance is a forum for problem solving and information exchange as we work to integrate and institutionalize health equity into the day-to-day practice of public health. The office of health equity is continuing to he can up and down our partnerships with the state, tribal and territorial organizations who are continued collaboration with our new public health instructor center that's now also a collaborator in the power of partnership alliance. So by aligning ourselves more closely with the public health infrastructure center, we seek to improve and increase community engagement among the departments of public health. Our office is also developed an overarching health equity partnership plan to facilitate the strategic engagement partners and again, since the last -- our last meeting in November, the offices convened meetings with multiple organizations that prioritize racial and ethnic minority groups, including the national medical association, the national Hispanic medical association, the American college of preventative medicine, a community based organization called choose healthy life and another organization called proceed that's focused on Hispanic and Latino populations among others so there are many more we've interacted with just since last November. In these meetings, we have sought to determine how we might be able to collaborate more closely in the future. In 2023, our office 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. So public health, health care and other partners joined the partnership and hearing from both CDC and external partner programs, you know, we're able to increase our collaborations, increase knowledge sharing so just in the two webinars we've organized over 2,500 partners registered and over 1,300 actually joined us. So one of the ways that we've been supporting the larger efforts that Dr. Cohen's priorities, we were -- we reached out to more than 70 community based organizations and national minority serving organizations to share with them the respiratory virus seen season prevention messages and to get feedback on how we could do that even better as an agency. We took their feedback, did an analysis of what they shared with us and we have shared that with ncird and they are working to address --

[Inaudible]

I can tell you we have some work to do in terms of improving the work. Neck slide. So task area two calls out the impact of CDC's organizational structure and how it affects the staff's ability to really 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, we have a strategic imperative on funding that expands the integration of health equity in this area. So through core, over I think a couple of years, we convened health equity and sme's from across the agency to figure out how we could incorporate guidance around health equity in a non research notice of funding opportunity template and so we're pleased that after that process, we have been able to put forward health equity considerations that will cue the NOFO writers to address health equity in the design of their NOFO's and after being published for publication, the applicants can address health equity in framing their programmatic response so our office is working closely with the office of grant services. We'll be launching a training series actually in the spring to help to socialize the health equity guidance that's now part of the NOFO template. I know that Dr. dauphin mentioned this early but I want to reiterate that at the beginning of February, CDC posted the full notice of funding opportunity for the strengthening of public health systems and services through national partnerships to improve and protect the nation's health, cooperative agreement and we see this as an important opportunity for community-based organizations and national minority serving organizations to compete for resources from CDC. In mentioning this new cooperative agreement, we welcome your assistance to help us spread the word about the new opportunity in the applications are due on April 1 of this year.

Next slide, please. So for task area three, our office is collaborating with other cio's to develop approaches and resources to facilitate the systematic and consistent integration of recommended practices for health equity science across the agency. Our 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, all things that you all have heard about today, we'll continue to hear about. So we're working closely with the office of science to increase awareness and application of the health equity science principles that was also published in public health reports so we feel very good about the rigor of those principles and the ability for sciences to really acquire them.

Next slide, please. So as the agency's health equity champions, we're working collaboratively across CDC to achieve key milestones towards the advancement of health equity and the acd's health equity recommend ages pray a framework for how we can chart additional efforts that would accelerate movement towards health equity.

We recognize health equity must be at the core of developing in the intervention, innovating solution, policy or programming for populations affected by health disparities, including the authentic representation and inclusion of community members and community based organizations. So as we look ahead, CDC is taking steps to shift how CDC conducts the public health research, surveillance and implementation science through corroboration and we're working to integrate health equity consideration and funding to address drivers of health and influence. We recognize we must recruit and retain a work force that represents diversity and academic disciplines, in lived experience and is prepared to do the work that will reduce and ultimately eliminate health disparities while also ensuring people have the opportunity to attain their best health possible. So if we could go to the next slide, I certainly welcome your feedback and comments but I also had two questions I would like to put before you. One of them is, given that our goal is to embed and institutionalize health equity in all of CDC's work, what suggestions might the acd offer that was not shared in my updates? Certainly we have the recommendations, we're pursuing those but if there's anything that has occurred to you that we are not doing in response,

please let me know. And then secondly, if there were two strategies that have implemented, both facilitate and accelerate the principles in our work, what would they be? So with that --

>> Thanks. Easy questions. Let's go ahead and remove the slide so we can see our acd members. And the floor is open for comments, questions, answers.

>> Answers are always welcome.

>> It's a shy group. While people are thinking, thanks, and I don't have any answers to your questions but two thoughts. We talked about this, and we talked a little bit at lunch. One of the problems we face, right, is that many of the community based organizations that are actually most important in doing front line work, particularly in communities of color are small and poorly funded. As a consequence, are unable to compete effectively for funding in the current funding environment and how rfp's are constructed. A solution to that is a longer one but anything that you could do through technical assistance and/or cooperative agree manies to entities that could, in turn, sub grant to these smaller community based organizations would be, on my list, a high priority because in the health equity work group, that was one of the fundamental issues that people were bringing to us that where the work is get dong and who it is doing the work is disconnected and is unable, because of business practices, to access the funding that's available. So working on that, including in your new NOFO would be one and then second, while action is important, we heard this morning that action is driven by data and one of the problems with health equity and equity measures is that we don't have any sense of uniformity, commonality across CDC program such that at the front lines, different parts of health require manies are working with different parts of CDC in measurements and health equity and oftentimes don't conform with each other and oftentimes focus more on individual measures of health as opposed to community members of health so anything that your office could do to jump start the ability of across cio approach to measures of health equity, that isn't formed by community and focuses on positive determinants at the community level would also be important. I'll get off the soap box.

>> Let me mention that the national center for chronic disease and health promotion has a surveillance system they call places and it's local data that is largely social determinants of health. So in our newsletter that's coming out by the end of the month, we actually have an article on places and so people can click on that and see the data that's available. We are also working with the public health data and surveillance and technology and the readiness and response to create a set of health equity metrics that would be used for readiness --

[Inaudible]

so there are lots of conversation that's going on around data. I would -- I am hopeful that --

[Inaudible]

>> anything that you can do to increase the likelihood that, for example, the chronic disease center specific measures become CDC-wide measures or evolve to CDC-wide measure $ kind of what I'm most strongly trying to advocate for because excellent measures that defer across different programs just create chaos and inefficiency and discouragement when you're in the front lines with limited resources trying to figure out what to do. Octavio? I'm sorry.

>> Lost in thinking about your questions and it's obvious, it's complicated because so much of why we have health inequities go well beyond what CDC is mandated to do. So just wondering how you're thinking about initiatives across agencies to really think about a real social determinants of health sort of model and is that happening? How feasible is it? And yeah. So that and then just with the focus on communities and given the fact that there's so much pushback around anything that has to do with equity in different states in our nation, I'm just wondering how whether or not that's become more and more of a challenge as well.

>> Yeah. So I'll start with that question first. It is. I mean, you know, regretfully the focus on what we're trying to do and the populations that are intended to benefit from them has become intensely politicized but if you look historically, this isn't the first time like this kind of -- we go through waves, if you will, of more and less focus on addressing health disparities and really being able to take the courageous steps that are necessary. So I think that if I could say there's good news is we made lots of progress just in terms of our knowledge and our understanding and even our discussions of social determinants of health so we're -- there's much more evidence and all kinds of things for those who would be moved by that. So we're in a different place but in terms of the actual investment in the resources to address social determinants of health through systems of public health, I think we still have a ways to go. What our office is trying to do through our partnership focus is to really start to engage, you know, certainly our traditional partners which really move beyond that and, you know, we're having conversations, they're informal at this point but with private entities that have health disparities and really start to think about how we could work more closely with them. But we have lots more work to do.

>> And I'm thinking about, you know, I go back to Chicago as an example and the housing and health that was done, you know, different departments and working across so I don't know if you're getting any support for doing those sort of initiatives that are not necessarily partnerships with health entities but partnerships with non health.

>> So not from our office's standpoint. This could be going on in other parts of the agency but not in our offices.

>> I think that would be important to start exploring. We want to see a difference in health equity. It's going to take that across departmental whole of government approach to it.

[Inaudible]

-- should be one that drives that.

>> Thank you for the presentation. A couple of thoughts on your first question.

I think about when the work with health equity with organizations, what are the sort of the inflexion points that can result in loss of gains made with health equity? And one of them has to do with the people.

So whenever there's personnel change but especially any positions of authority where there's been a change in leadership, and it could be cross, you know, from one unit to another or a totally new person comes in to the CDC, I would recommend especially for positions of authority that it would be required they come and meet with you. And with your staff to emphasize how important health

equity is to the CDC enterprise. In addition to that, to elevate and to keep folks accountable, because over time, time also has a tendency to soften either our approaches or other issues start to gain greater priority or, you know, lack of a better, you know, term within that context, I'm thinking of how do we keep things account ZABL and PRESH when it comes to health equity?

One -- the fact that you're here with acd every time is one thing. I'm thinking it would be really neat if also you would have -- talking about the metrics as you identify them and they get solidified, creating a wished windshield or a summary page that you share with us, the acd, as a high level. We don't need to get into the details or micro manage but we love to see what is happening, how do the metrics work and as they start to see especially over the course of time, we can then weigh in and at a granular level, at that high level, so to speak. Also not being able to share with acd but it's shared with Mandy, Dr. Cohen and then all the units know that. I just feel that there has to be an additional level of accountability when we're trying to make cultural shifts and become embedded across interdisciplinary fashions. I think that's one way to keep it, you know, at a front of mind, so to speak. And can you tell me, what was your second question?

>> It was -- there were two strategies that have implemented both facilitate and accelerate the integration of health equity principles in our work.

>> Thanks. I think maybe I kind of answered a little bit of that one, too, just didn't realize it. But I'll throw that out there to consider it. I don't know what else you would need or if that resonates with the rest of my colleagues here at the acd to actually have you -- help you implement that kind of accountability measures that is shared at a high level with obviously the director but also with the acd because I think that would keep it top of mind.

>> thanks. Rhonda?

>> Hi there. I listened to your presentation and I thought to myself, I hope she has at least six cloves because it was such a wide breadth and thing and all those things need to be addressed. It's just actually ginormous and I'm used to seeing challenges and things being completely near the impossible thing but this is so incredibly important. And you asked, what would we suggest. I don't know all the things that you have to do, OK? I can tell you that unless you pick something common that goes across all of the major leadership groups within your organization, having performance measures tied to it and the performance measures tied to not only their accountability but -- just people at CDC get bonuses?

Probably not but I think you get what I'm saying here. You have to tie it to something. It's got to be something concrete.

Whether you have new health equity measures or not, you can develop those with folks but at the same time, you already have information about disparities and diabetes, hypertension, heart disease, asthma, vaccines, you got enough colon cancer, prostate cancer, you have enough of that that you could pick -- I don't know -- five, ten of those by geography, by region, by county, whatever, pick, right?

You all need to row in the same direction and so maybe there's some parts of the CDC that have nothing to do with colon cancer but there's probably a lot of them that do, including the informatics people, the epidemiologists, etcetera. You have to pick something and have a performance

measure that everybody can see and be held accountable to and then you've got to report on that so that it is visible. Octavio said something about Mandy. Mandy and more like in the public to see the progress made. I'm so sorry.

I wish that we could clone you.

I think your life would be a little easier but you're doing -- you're doing health disparities of populations and you're doing dei at the same time and I think those are two massive jobs and if I had to pick, I know they're both related and they both help each other out but I would focus on the populations that are currently suffering and I would be focussing in on those disease states and conditions that are avoidably causing suffering. So I can't speak to what you do every day because I promise you, I would bow down if I were there with you to all the things that you do but you have to pick something concrete and everybody has to row toward it and it's got to be measured and reported out. You know, paper is magic.

So is electronic data but you have to report it out so people can see it and that's where people feel motivated to move.

So even the people most skeptical can still see whether or not movement and progress is being made. Does that make sense to you?

>> Absolutely.

>> I've had three cups of coffee today so maybe not.

>> I want to share that we actually have moved the DEIAB team out of our office. They are now with the chief operating officer for exactly what you said. I always argue that we had the lead in public health. We need to put before, you know, our whole purpose in why DEIAB is important is its contribution to reducing health disparities.

>> Exactly right.

>> That actually just happened at the end of -- at the end of January. The other thing that we've done through our core initiative is to ask the national centers institute and offices to commit to two goals that they are going to pursue and drive toward health outcome.

So we're in that process right now. We've had 11 centers to do that. I think there are 18 when we first got started. So we are in the process of setting up, you know, but there is already a reporting system that goes along with core.

>> OK

>> So in terms of what metrics we will be collecting from all of them, I'll be able to share that in our next meeting.

>> That will be good. And if I had one more piece of advice is that we had -- I don't have any other responsibility that you have now but we have people who would pick perinatal care or they would pick diabetes and we would say, OK. We have enough but we need teams to move, right? We watched as people who don't have direct contact with it as far as they knew, they kind of disengaged and we had to pull them back in. So we had to do the health equity strategy, five-year

strategy and have them focus, we went to ten health disparities and we basically said, you know what? Just because you're sitting over there in finance doesn't mean that you're off the hook. You get to come to the meetings and you get to participate and talk about how the finances is going to support the disparity interventions, the progress reporting, et cetera. If you're in OPs and sitting off to the side thinking that's not really me, it actually is. Particularly if it's about making sure the people get the information they need, that the background operation, same thing with I.T., they may be part of your team and not a bystander. Not an observer but an integral part.

Do you already have that going on?

>> yes.

[Inaudible]

>> -- also where -- -- sits and we work closely with the office of science and then we have -- I want to call them discreet collaborations with some of the national centers so --

>> Are there individual performance measures tied to the success of those achieving those measures? That's -- so we invite people to come to meetings and they would sit on the laptops and be doing any other thing but we tied it to performance measures, individual performance measures, right? So I.T. gets a grade in their performance evaluations about did your contribution lead to success?

Was your success achieved? And that's -- do you know what I mean? It can't be just that they're taking up space. They actually own some accountability so the rest of the committee can disagree with me but I found that people tend to pay attention and actually lean in when their performance is actually assessed based on what the overall performance measures are. Right?

>> We don't have individual performance measures around equity --

[Inaudible]

>> yeah. So it's not as hard as it sounds because if they are working with you on whatever areas you're focused on, whether it's maternal child health, et cetera, pick something. Was there measurable improvement overall? Whether or not they contributed big or small to it, was there improvement? Part of the team. At least, you know, you have to kind of make it so it works at a broader level in terms of the accountability. I have people that used to report to me that did contracting and for the life of them, they couldn't see how they were supposed to be responsible for health equity and I said, well, you are the guys doing the contracting between the providers and the health clients. You can actually build into your contracts the health equity performance measures and requirements. You could build in the part about having to share data. Just look beyond the usual is what I'm saying. Right?

You've got people who are serious experts and smart as a whip on the disease states, the prevention, et cetera. The true blue. But you also have folks in other areas of your operations who can help you and who need to actually be held accountable, too. Otherwise, you're going to sit there and do everything and I'm going to see you next time and you're going to be shorter.

You'll be like now a little pencil, OK? So you have to share this a little bit more. You'll find that you might hear some things that you never thought about before. Right? We had people who are contributing to our communications and engagement strategies who were working over in government affairs or working over in policy and I don't want to shock you but an actual cfo who cared and leaned in and helped us find other solutions in financing, right? Not to preach at you but I just worry about you and the team that you need to get the other folks on some of this. Not just on paper but in actual reality. Does that make sense?

>> Yeah. Absolutely. Thank you for that. We concur.

>> Thanks. We'll get out a tape measure to measure your height.

Last comment.

>> I'm going to step back a little. I think Rhonda can give you very specific guidance. One of the things I was thinking about as we were talking was there is just so much you can do. It becomes virtually impossible to do that. Knowing that you have a small office, one of the things to think about and something we've been doing because we have our equity office itself is really having that office serve more as a resource to establish what best practices actually are and provide frameworks for us to use throughout the organization and to provide that as a resource, not expecting you to do the work. You're providing best practices to your --

[Inaudible]

>> in their conversations today what has been working consistently is --

[Inaudible]

and also community engagement.

It's not any public health agency and that's an area that needed improvement from an equity perspective so UKT prioritize and focus on another couple areas where best practices and share those as a resource to other cio's to say, here. This is what I recommend and then with your limited bandwidth, you could focus in on the CDC priorities because Dr. Cohen has said what her priorities are in terms of readiness, overdose, young families and --

[Inaudible]

that's really, really broad but if you could challenge your --

you know, share these best practices --

[Inaudible]

allows you to focus on, that's why there's --

[Inaudible]

I, too, share Rhonda's concern that if you try to do everything, you're not going to get anything done and you're going to deplete yourself of all energy and enthusiasm and we don't want that to happen. So I guess that would be a stepping back a little bit. Specifically we have some equity

competencies that we were using in performance management that I would be glad to share with you if that would be helpful to look at. It's not rocket science but it's just seeing what kind of accountabilities do you want --

[Inaudible]

demonstrate equity skills and --

[Inaudible]

it could help.

>> So let me say that our approach has been over the last -- certainly the last three to four years, we've really focused on creating the standards, right? So that when people say, well, what is health equity, we get into these debates, what is it of value, et cetera, so no.

It's a practice so we've had to lay that out. We've created training programs, we've tried to create the substance of what it is that we want people to do.

And so then the next parted that far is socializing that, getting that out across the agency and, you know, health equity needs in all, if not most of our cio's who are probably doing a similar thing. So having this kind of single or even unifying sort of approach is tough, right? It's tough. But it's not, you know, impossible. So -- and also all of this takes way longer than you would imagine, right? So we can be -- ultimately that's our goal is to be a resource to the agency but we have to be able to have, define what it is we're being a resource to do. So I think that's where, you know, we have no -- we can't do this all by ourselves. But we do need to be able to say what that is and I don't think that -- I think depending on where you sit in the agency, what your cio is, like even I think about the labs now are trying to identify what health equity means to them. So everybody, there's --

[Inaudible]

processes. We're providing technical leadership, we're coordinating, collaborating but not -- but also along with the cio's are doing.

>> thank you. As always, really great discussion and we appreciate you laying out those questions at the end and more importantly, as I thank you for those of us who appreciate the work you're doing on this very important but difficult issue to move forward. We look forward to hearing from you next time.

>> OK, folks. We're nearing home stretch down to the last agenda item. And this is the session where we're going to be hearing a little bit about the work that's being done at CDC to draft terms of reference for a new work group for the acd that is on communications and public engagement and I'm happy top welcome Andi who is the deputy director for policy, communications and legislative affairs and Kate who is the designated federal officer for the work group. So welcome to both of you and I think Andi will start off, is that right?

>> Can you hear me OK?

>> I can.

>> Great. You never want to go after someone says you're in the home stretch so we'll be really energizing at the end of the day conversation. I know you've had a packed agenda today, really happy to be able to join you to talk about the proposed communications and public engagement work group and my apologies that I can't be there in person this time around. I'm hear in dc. So I'll just sort of quickly introduce this. I think we can go probably right to the next slide. So you know, I'll just quickly introduce this and hand things over to Kate who has been doing a lot of work in taking on this. As many of you know, my role as a newly created leadership role at CDC aimed at providing wholistic leadership across agencies, communications and policy work streams so I'm excited about this opportunity to continue to build on the efforts to optimize effective communications and frankly, to leverage all of you in your expertise and experience as we're thinking about this really important work. You know, we know, obviously we have spoken about it a lot on this work is really central to CDC being trusted, highly effective, embedded in the larger, integrated system that protects public health and I know you heard a little bit earlier from Kate today on CDC moving forward and just to sort of connect the dots, I wasn't on the conversation but to the extent it wasn't explicit in that discussion, prioritizing health communications by improving how CDC interacts with the public remains really central to that work and there's been a huge number of deliverables that Kevin who is on -- who runs our communications work that Kevin and his team have really driven forward. Huge changes we've seen following that work. So these include things like building a new, easier to navigate website, more real time communication about health threats, really thinking about transparency and what that means and as well as things like plain language training for scientists and staff across CDC so that when we are communicating, those communications, we're actually communicating, right? We're not just putting things in the world and crossing our fingers. You know, it almost goes without saying that the pandemic really laid bare the role of communications and protecting health. You know that it's the right information, it's getting them to the right people and the right way, the right time and that there's huge implications for sort of weather and how people can use that information then to protect themselves and their loved ones and, you know, a note on that and the extent to which communication gaps with historically marginalized populations RAEM continue to examiner -- persist and are an important part of this conversation. This continued to evolve, right? We're seeing communication as a really shifting ground, not just because of sort of the moment we're in, in public health but also the sort of realities people are seeking, different types of content, shorter form, more accessible rate in communications, blogs, visuals, et cetera. Frequenting different communications channels with the proliferation with digital methods of communication and really thinking about what all that means for the ability to reach the public with the communications that we really need to reach them to be optimizing public health. You know, new challenges all the time, including folks just sort of inundated with increasing volumes of information both good information, misinformation, disinformation overall so the challenges around really breaking through there. So with all of that in mind, and it's a lot, the communications and public engagement work group is being established to assist the acd in developing recommendations for all of us on agency-wide activities related to how to communicate directly and more effectively with the public and, you know, in particular with the focus on reaching local communities with messages that will resonate and will have an impact that we're looking for. The work group will convene a balanced group of subject matter experts to assist in the development, advice and recommendations to CDC around the effective communication goals. So the next slide gets at some of these specific goals. We know there's a lot of important

dynamics at play here but we've identified five key goals that we think are most important here. So the first one you'll see here on the slide around building relationships and communicating with trusted Messengers so this is thinking about everyone from clinicians, community leaders, health department officials, we know it's not the same people in all of the same communities with all the same audiences but really thinking about what those relationships and mechanisms look like. Number two, improving risk communication practices in particular, really particular challenges in that space. Number three, delivering more action-oriented and focused communications to help people protect their health so this is thinking about how are we using story telling and how are we really thinking about what messages are going to be most effective. Four is tailoring our messages and communications methods where we can for audiences, particularly again for those underserved communities and then five, I mentioned briefly transparency earlier but really continuing to increase transparency by stepping up communications, content, the reach of our communications, so thinking about how are we using different channels, what's the place for social immediate I can't recollects for blogs, for tv, for emerging platforms and how do we bring that to bear to sort of fulfill the promise we have made around transparency. So I'm going to stop there and pass things over to Kate from our office of communications. Kate is going to provide an overview of the proposed composition and the charge of the work group as well as the next steps just to really thank Kate for the work she's put into this already and in the work yet to come and for shepherding this really important work. So again, thanks for having me. Good to see you all even if you are small dot in the distance, a couple of you I can make out and really appreciate the conversation today.

>> Thank you. And thank all of you for your work on the acd.

I've long respected the importance of the contributions that you all make to CDC. And I'm just going to have to take a moment here. Just bear with me for one second but I think every discussion of the acd today mentioned, touched on or gave acknowledgement to the important role of communications and public health and I've been waiting a long time to have that happen. There are undoubtedly colleagues of mine on the phone very happy to be where we are at this moment. This is a really important charge to take forward. Here's part of the why it's affirming and then I'm going to jump to the details.

Why it's affirming for me. I started my public health career as a communications director and state public health. I worked 20 plus years at CDC in communications. I was the acting communications director approximate the early months of 2020 and the last eight, nine months of the trump administration. And it gave me a very unique perspective. I really saw close up what was working, what wasn't working and the impact that the communication challenges had on what we were able to really TAISH how nimble and how adaptive could our communication STRAT GIZ be in the face of what the nation and the world were looking at and so I want you to know up front that I'm honored to serve in this role and I also want you to know up front that I am all in. Slide forward, if you would. So you've all received the terms of reference and hopefully have had a chance to read it in detail and Andi did a great job of really lifting up the background and kind of why -- what it is and why we're here. I'm going to go through some of the important logistics and I'll say that the draft name right now is the communications and public engagement work group. We have two co-chairs that have been identified and so that's Dr. Martinez and

Dr. medows so thank you very much. And we're looking to have the communication and public engagement work group, competition and Andi touched on this a little bit but looking at no more than like 15 members but we want the breath of comms background because that's really important and there are different areas of expertise that we want to make sure is at the table from the communications perspective. But we also need community and partner engagement experts, we need, of course, public health and practice and the implementation piece of public health and then we also need behavioral science and people who have expertise in working on behavior change campaigns, all of those elements are really critical to the work as a whole of this work group. Here's the charge. Here are the potential areas of exploration and, you know, I just confessed to how long I've been here so I will say that it's not a terribly new set of questions.

These are questions that in communication space we've asked ourselves and we wanted to explore and push the envelope on many of these things for many years. What is unique and exciting now is that it is a shared sense of urgency that we get this right. You heard Andi say that pandemic laid bare the communication infrastructure or the problems that we had and I would say that's like hard to say what almost an understatement it is. It's hard to capture how much of a spotlight it put on the challenges that we have faced over the years. So these are just some of the questions and it really will be an important opportunity to have outside voices who are informed and who understand this world to really help recommend to the acd ways that we at CDC can make some much needed progress in these areas and more. So just a few quick next steps. After, of course, based on the result of today's vote, we will need to get quickly to the work of recruiting the membership to the communications and public engagement work group so wanting to solicit interest from, of course, acd members and yourselves but also know that we will be submitting a federal register notice to invite participants, TERNL -- external to the CDC and acd to join and setting up a review panel to help establish the criteria and then make the selections of membership. We have to schedule that meeting and before the first -- the third quarter of 2024 and then, of course, submit some report to the acd and that might be summary reports to the acd but as that case may be, we want to wrap this up by June of next year. And I'm happy to take questions or -- but thank you all.

>> thanks very much, Kate. I think it's OK to go ahead and remove that slide so we can see the folks. I think I'll go first without putting either Rhonda or octavia on the spot, asking if you have any additional questions or responses. Go for it, Rhonda.

>> I think one of the things that we talked about in the discussion prior to this meeting was also making sure that we include preparation for timely addressing of misinformation so it's not only what we need to say accurately, clearly, understandably and in a consumer approach. We also need to be able to address the misinformation that so easily takes down the credibility of what we're trying to say. So having somebody that has expertise in that area is really going to be important as well.

>> Absolutely. The field of communications at large is struggling with that very issue.

We are not unique, although it's certainly uniquely affecting us but I agree that that expertise will absolutely be included in what we're -- what we seek from our members.

>> Octavio, any comments?

>> One really great, this will be put up to a vote, work group, sorry, and I'm honored to be a co-chair along with my colleague. I want to add at lunchtime as we were discussing there are multiple levels, there's the provider level, there's the communicate, the providers and of course, each one of those, there's sub categories but there's also, I think, the systems level and I think the focus has been a lot on discussion -- I mean, on communicating with community, we can't leave the other pieces out and so I think that's going to be really exciting. I think the 15 folks that come on the work group will be key as Kate has pointed out that expertise but also I think it will definitely give a lot of not only insight and expertise but will give a lot of credibility to the work group that we truly are listening to all our communities to be able to address the issue because at least in my opinion, David, I think everyone I've discussed was just a common person in Texas or a provider or even talking to some folks that are positions systems level, this is a huge issue for everyone. Everybody is concerned. Some might have different reasons for that concern. But I think to Rhonda's point, the misinformation environment that we're currently in and how social media can impact things so quickly will obviously be top of mind in addition to the other component that it's not embedded in here but I think it is extremely relevant and it has been brought up, DAICHD, earlier which is this has a lot to do with trust and building not -- rebuilding the trust of the CDC but also rebuilding the trust that inherently exists in relationships that are respectful of each other. I think if we take that perspective, I think we can make some wonderful recommendations for the CDC to hopefully follow through on.

>> Thank you. Any comments or questions from other committee members, including any comments or questions on terms of reference?

>> I was really pleased to see that relationships and --

[Inaudible]

I think especially in a time when CDC has lost the trust of the public and health care providers, others in the nation that we establishing the trust may help from the trusted Messengers. I was telling David during lunch, when I first came from Chicago, the health department was not known as a source of information or trustworthy information so what we did is over time, partnered with the American academy of pediatrics and OERP trusted resources to help establish our trustworthiness as we moved forward. Over time, VEEFBT -- eventually people did recognize us and trust the information. I think as we move forward --

[Inaudible]

sources to establish --

[Inaudible]

>> thanks.

>> I was just saying, I couldn't agree more with that is it's always an important practice.

It's a more important practice now that we -- as you build trust, you maintain trust, you lose trust, rebuild trust, there's a continuum. We know that we cycle through it and the ability to connect with and have meaningful relationships with a wide set of partners who can carry that message with us and for us and do so in ways that are more meaningful and more impactful to the communities that

they serve, that's always the winning approach and I think we're right in that space right now where we're having to truly double down on rebuilding.

>> I see that Josh has his hand up.

>> Thank you for the great presentation. You know, I wonder to what extent state and local and tribal territories assist in this effort? One of the things that has happened is sometimes they feel a little bit cut out of information. I don't really think so much of CDC as maybe fda, fda announces something and the local and state health officers don't know what it's about and are kind of scrambling to figure out and they wind up losing people's attention. It's sort of like a whole -- public health is kind of, you know, a team and so if CDC is focused on its partners, its community partners and its messages to the exclusion of how others in the public health world are going to be communicating, it can be hard to really be fully successful.

I'm just curious how you think about that.

>> So we absolutely wanted the public health perspective at all levels so we want that perspective both represented in the work group itself but also represented in the strategies of who we're trying to engage so when you think about, you know, trusted Messengers, you know, those -- that those partnerships with state and local and territorial and tribal health departments are just really critical relationships that we need to rethink how we do that and readjust the information sharing. I will say you were kind to say that maybe it's not so much with the CDC but I think, you know, we have not always gotten it right, either, right? So there's been definite times where we could have improved communication with our state and local health partners.

>> Thanks, Josh, for raise that go you raised it eloquently than I was going to but I do think that many state and local health departments no longer feel like they're in that role of being the trusted Messenger so their agenda would look similar to this and it's complicated, right? One of the keys to my understanding of effective communication is coherent SI, consistency across measures so how to figure out how to make that happen more effectively in this day and age is going to be the important part. Jill?

>> So this might be totally naive and I apologize if it is, but OK. Vaccine mandate. I often wonder how many people are objecting to the vaccine versus objecting to the mandate? And I wonder, you use risk communication a lot as if CDC is deciding the risk or, you know, public health is deciding the risk for a person. Is it fair to phrase it as these are the pros, these are the cons, you're an adult, work out your risks? Just -- I don't know. What we're doing now isn't working.

>> Right. I will -- having spent years in risk comm space discreetly, I will say this. It is much less, much less, Jill, about how we think about risk and then choose to communicate it. It's all about risk perception and we don't always know enough because the challenges of doing that type of research in public health but risk perception, it is what drives behaviors and so understanding how audiences perceive these issues and then being able to create solutions and deliver messages and use comms strategies effectively, you have to be able to start with where are our audiences on this spectrum and we need to know their perceptions of risk.

So not naive.

>> OK. If I can add, I also think there's not one answer to that, right? Depending on the topic, depending on the audience, depending on the moment in time, right, so I think that all goes to what you were saying but, you know, I think that's part of what this group company assess out is how do we think about that in these sort of different contexts because like everything, right, there's science and there's art and I think communications and certainly public health communications is a place where they meet.

>> I would like the discussion to continue in the work group.

OK. Well, I will entertain a motion.

[Inaudible]

>> we can have discussion after a motion as well.

>> Thank you, Jill. Good segue.

David, I would like to propose a motion to the act that we stand up the communications and public engagement work group along with the tor.

>> and we don't need this slide.

Let's have the members back.

Perfect. And did I hear a second? Was that Rhonda?

>> Yep.

>> OK. Further discussion. Yes.

>> I was just looking back in terms of reference and just to see, I'm wondering, there wasn't -- and again, it was marginalized or most impacted communities and I do feel like as we --

>> I think there is. It's in the longer set of -- it's tucked in the long version of the questions towards the end. If it isn't there, let me say that it was at some point and we'll get it back. But it's critical that we work with the marginalized.

>> Yeah. Thank you.

[Inaudible]

>> any further discussion? If not, all those in favor of the motion just stand up and please signify by raising your hand or saying aye. I would say opposed neglect but everybody already voted so the motion pass as none -- passes anonymously. Thank you for your leadership here and your leadership moving forward in making this happen. We will go ahead and send out a quick note to acd members as we mentioned to solicit any interest and in a simultaneous way, I think the federal register of notice was about set to go, right?

>> Yeah. Carrie can correct me but we drafted it. It's like with our office and so our plan was to be able to like have it go out this week, I hope, or early next week.

[Inaudible]

>> we'll make sure we send it to all the channels as well. We want to disseminate this really widely.

>> Next week. Yes. Any further discussion on this issue? If not, thank you both very, very much. And we're now at the end of the meeting. We have five minutes for closing remarks which I don't think we're going to take unless you talked before. She needs to. I will take just one. First off, thank you to the acd members today for your participation and thoughts.

It's really, really excellent discussion. Importantly, thank you to Deb and the wonderful acd support staff that we have that makes it possible and I get a little bit a glimpse of that, it amounts to swimming under the water, there's synchronized swimming that goes on to make these meetings happen and it's been remarkable and thanks also to all the CDC leadership that was here today for their willingness to engage with us in these important discussions.

>> Thank you. And thank you, David. David is good at keeping me on track. We need to get an agenda coming up but I do want to echo the thanks to the team and to all of you. I'm delighted to have Dr. Gale join us and everybody knows is a process to get onboarded through HHS. We do have additional members that we hope we might have in place by the next meeting. We have been waiting patiently so hopefully that -- I know. And I did also just want to mention that on our acd webpage, there's a spotlight we plan to keep there just to really commemorate her and memorialize her service and I am always around if there's anything that I can do, please let me know. If you have suggestions for the next meeting, shoot them to me and David as well.

>> Anything else in the good of the order? We're adjourned.

Thank you.