The Report of the Partners' Task Force on Objectives

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PARTNERS' TASK FORCE ON OBJECTIVES

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Partnership for Prevention took on fast-paced tasks that pushed the organization and its staff. They rose to the challenges, adding value and producing high-quality work as they engaged Partners, convened the Task Force, analyzed and reported results, and stepped in to help when needed. Thanks and recognition to Tracie Bryant, Antonio Edwards, Steve Jenkins, Anne Kiefhaber, Susan Maloney, Natalie May, Jud Richland, and all who stepped in to help stuff notebooks and express packages in order to meet deadlines.

The numbers of people involved in varying roles, the number of tasks mentioned, including shoehorning this into the already busy schedules of Task Force members, should leave readers gasping that this all took place during a four-and-a-half-month time frame. So we urge CDC to keep asking questions, keep listening, keep reaching out to your sister agencies in the Public Health Service, keep finding ways to work in concert with the multitude of domestic and international organizations with similar missions, and keep grasping to understand what communities are telling you about their programmatic needs. Working together in this way will ensure that the public's health is protected.

December 15, 2006

Dear Members of CDC's Executive Leadership Board:

It is our pleasure to submit to you *The Report of the Partners' Task Force on Objectives*. In accordance with the CDC director's intent for the Task Force, the report covers our reflections on lessons learned during the process of partner and public engagement, and our interpretation of the rich discussions about the criteria and objectives during the engagements and the priority-setting exercises which were conducted.

We admire your commitment to improving the programs and services that will continue to improve health both here and abroad and appreciate your desire to incorporate today's realities of globalization, rapid diffusion of technology, increased access to communications, and changing demographics into your planning. We also appreciate your desire to allocate funds in the ways that are most cost-effective for achieving improved health.

Your partners in public health have provided you with much to consider. They continue to ask how these objectives or any objectives can be accomplished in the face of crumbling public health infrastructures and a fragmented healthcare system. They ask how resources will be allocated among and between the population at large and those whose health is disadvantaged by virtue of who they are or where they live. They ask exactly how roles and responsibilities are shared among varying levels of government during disasters. They ask for clarity regarding how CDC will work with its sister agencies within the Public Health Service, with other federal agencies, with state and local health agencies, and with the myriad of private organizations that share visions of better health. They ask what it means to partner with CDC. They ask how the United States will lead on health issues on the world stage. They ask CDC to exercise leadership to address the social determinants of health, to improve health literacy, and to tackle emerging threats to health from infectious diseases to climate change.

Daunting challenges, perhaps, for an agency laboring alone, but these objectives can be achieved through the power and leveraged resources of collaboration, shared responses, and joint action. That is the vision inherent in the words of this report. That is the vision that is yours to embrace and to lead.

We are confident that this report accurately represents the sense of the Task Force. Still, because of time constraints, we did not seek formal endorsement from Task Force members. In many cases, this would have required the Task Force member to obtain official endorsement of his/her organization, which was completely impractical in the time allowed. Thus, this report does not represent the views of the organizations represented by Task Force members.

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Co-Chairs

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EXECUTIVE SUMMARY

During the fall of 2006, the Centers for Disease Control and Prevention (CDC) undertook a process to obtain input from partners and the public to refine and establish priorities among the agency's objectives developed to achieve its four Health Protection Goals:

1. Healthy People in Every Stage of Life (Healthy People)
2. Healthy People in Healthy Places (Healthy Places)
3. People Prepared for Emerging Health Threats (Preparedness)
4. Healthy People in a Healthy World (Healthy World)

Working closely with Partnership for Prevention, CDC established an independent Partners' Task Force on Objectives to monitor the process and to summarize and interpret the information that was collected. This report presents the results of the Task Force's work to date.

Eight events were held to engage approximately 275 participants in this endeavor. Participants in the events included partners from national organizations, tribal leaders, members of CDC's Health Disparities subcommittee, and state and local health officials and allied organizations in four communities. At each event, CDC's goals, objectives and proposed criteria to rank the objectives were explained. In small groups, participants discussed the proposed criteria and the objectives for one or two of the goals. Participants in six meetings were asked to identify the one-third of objectives they considered highest priority for each goal. At two meetings, participants selected their top 25 objectives. All participants' comments were captured and synthesized for Task Force consideration. It is noted that the results from these engagements cannot be generalized to any larger group.

The extensive commentary on the objectives is discussed in detail in this report and priority objectives are highlighted. In general, participants felt and the Task Force concurred that the objectives would be substantially improved by eliminating overlap among them, using consistent language in similar objectives, and making objectives parallel in structure and the depth and breadth of health issues addressed by each one. Concerning the proposed criteria for assessing the objectives, participants and Task Force members felt strongly that CDC should clarify how, when, by whom, and for what specific purposes the criteria will be applied to selecting priorities among objectives. Task Force members also wondered how emerging issues, such as climate change, would fare with the proposed criteria.

Drawing on all the comments made by partner and public engagement participants, the Task Force commented on several overarching issues that were judged to be of paramount importance.

- A strong public health infrastructure—trained workforce, comprehensive data and communications, and advanced systems and policies—will be essential to accomplishing the objectives. Why is there no objective that addresses this issue?
- How exactly will health disparities be addressed in the objectives and in any agency program and funding priorities that emerge? Similarly, how will health literacy be addressed?
- Participants, especially those at the community-based and tribal leaders' meetings, emphasized a holistic view of health and health services which encompasses the biological, psychological, social, and environmental aspects of health. This point also addressed the

strong desire on the part of service providers to reduce fragmentation among programs and services. The Task Force pointed out that this view resonates strongly at the community level and is culturally sensitive.

- Participants and Task Force members concur that CDC must be very clear about how CDC's objectives relate to other health objectives, especially Healthy People 2010 and 2020.
- Task Force members urge the use of sound project planning and management practices as CDC moves ahead with partner and public engagement.

1.0 INTRODUCTION

The Centers for Disease Control and Prevention (CDC) has begun the process of developing and prioritizing objectives to guide the agency's efforts to achieve its four Health Protection Goals:

1. Healthy People in Every Stage of Life (Healthy People)
2. Healthy People in Healthy Places (Healthy Places)
3. People Prepared for Emerging Health Threats (Preparedness)
4. Healthy People in a Healthy World (Healthy World)

CDC recognizes that its ability to achieve its objectives will be greatly enhanced by enlisting the active participation of its partner organizations and the public at large, both to assist in formulating the objectives and, later, to work with CDC to implement programs to accomplish the objectives. Thus, working closely with the public health policy organization Partnership for Prevention, CDC established an independent Partners' Task Force on Objectives to observe and help guide the process of obtaining partner and public input on the objectives and to summarize and interpret the information that was collected. This report represents the results of the Task Force's work to date, and the Task Force assumes all responsibility for the observations and conclusions herein.

The Task Force commends CDC's intent to work collaboratively with its partner organizations and the public. CDC shared its "starter" list of objectives with its partners and the public even before the objectives were fully polished and refined; by doing so, CDC appears to have increased the likelihood that the input received will carry even greater weight as CDC finalizes its objectives.

A guiding principle in the Task Force's work has been to review and consider each and every piece of input that emerged from the series of partner and public engagement events that CDC convened from September to November 2006. (These events are described in detail in section 2.0.) The Task Force members have exercised their best professional judgment in summarizing and interpreting the input that was provided.

Following this introduction, this report includes three sections. Section 2.0 reviews the series of partner and public engagements conducted to obtain comment on CDC's proposed objectives and criteria, and also describes the methods used to analyze the findings and input. Section 3.0, which specifically addresses the objectives and criteria, describes and interprets the information collected at the eight engagement meetings and recommends high-priority objectives selected by careful consideration of the findings from the partner and public meetings. Finally, section 4.0 contains the Task Force's overarching observations about the process used to obtain partner and public input as well as numerous observations about the starter objectives themselves and the criteria proposed to help rank the objectives. The observations in the report are, in some instances, critical of the partner and public engagement process or of the objectives themselves. Nevertheless, the Task Force is impressed by CDC's commitment to carefully consider the information in the report.

The way CDC ultimately uses this report, however, is up to CDC itself. To help ensure the integrity of the process that has been used to date, we recommend that CDC report back to the Task Force periodically to describe how the input received from partner organizations and the public was used to revise and rank CDC's objectives.

This report is being delivered to CDC's Executive Leadership Board (ELB), whose membership includes the senior leadership of the agency. The ELB will oversee the development of Goal Action Plans, which will include key strategies, actions, and measures for each objective.

The Task Force appreciates the opportunity to have assisted in providing partner and public input to CDC as CDC formulates its high-priority objectives. The Task Force looks forward to working closely with CDC in the coming months and years to help ensure that the agency's objectives meet the needs of the nation, as well as working collaboratively to promote health and prevent disease globally.

2.0 The Partner and Public Engagement Process and Methods

CDC, in conjunction with Partnership for Prevention and The Keystone Center, conducted a process to collect input from partner organizations and the public on a set of "starter" objectives related to CDC's Health Protection Goals as well as proposed criteria to be used by CDC to determine which objectives are of highest priority. The Partners' Task Force on Objectives was established as an independent group to help monitor the process of obtaining partner and public input and to summarize and interpret for CDC the information that was collected. Input was collected at eight different events:

- A two-day conference of CDC's national partner organizations
- A meeting of CDC's Health Disparities Subcommittee of the Advisory Committee to the Director
- A meeting of tribal leaders at the Annual Consumer Conference of the National Indian Health Board
- Four public engagement meetings convened in conjunction with state and local health departments in Oakland, California; Boston, Massachusetts; San Antonio, Texas; and Little Rock, Arkansas
- The president-elect session at the annual conference of the American Public Health Association

Each of these meetings is described briefly below.

2.1 Partners' Meeting

On September 19–20, 2006, CDC and Partnership for Prevention convened a conference in Washington, D.C., to obtain input from external partners from national organizations on CDC's starter list of objectives and the proposed criteria. CDC and Partnership for Prevention invited 264 organizations to the conference, and 106 organizations were present.

Participants first met in small roundtables to provide input on CDC's proposed criteria. Each roundtable was facilitated by a CDC staff person who completed a written summary of the discussion. In addition, participants were invited to submit written comments on the criteria. Participants addressed six main questions in the roundtable discussions:

- Are the criteria clear?
- As a group, are they balanced and reasonable?
- Are there any major criteria missing? If so, which ones? Please justify.
- Regardless of criteria in the past, looking forward, should some of these assume more prominence or importance in CDC priority setting?
- What kind of discussion might we have with the public about these criteria, and what would we want most to learn from that discussion?
- Is there any sense of priority among the criteria? If CDC had to choose some small subset of these criteria to weight most highly, which ones would you choose and why?

Participants then met in roundtables organized by goal—Healthy People, Healthy Places, Preparedness, and Healthy World—to offer input on CDC's starter list of 80 objectives. There were two rounds of these discussions (i.e., each participant had the chance to discuss the objectives in two of the four Health Protection Goals). At each roundtable, participants addressed the following questions as they related to the objectives in the specific goal area:

- What is your overall reaction to the objectives as a group? Do they look balanced, comprehensive? Do they cover the main components of public health and CDC's work?
- Thinking about the criteria we have just discussed, and particularly those that you thought should be weighted more heavily, do these look like the "right" objectives based on those criteria?
- If not, are there any big objectives missing from the list? What are they, and which criteria would you use to make the case for adding them to the list?
- Are these objectives at the right level of specificity? If not, which ones might benefit from more (or less) specificity/granularity?
- Thinking about your program/organization and its main work, do you see *yourself* and your work reflected in these objectives?
- How can we best use these objectives in the public engagement process?
- What are your priority objectives for engaging/mobilizing the public around these issues?
- What are your priority objectives for partnering/collaborating across sectors and across levels of government?
- What are your priority objectives for overall priorities?

As with the criteria discussions, facilitators prepared discussion summaries, and participants were invited to submit written comments on the objectives. At each roundtable, participants were instructed to identify the one-third of the objectives that they considered highest priority.

Following the roundtable discussions, the participants convened in a plenary session to select the 25 highest priority objectives from the list of 80 starter objectives.

2.2 HEALTH DISPARITIES SUBCOMMITTEE OF THE ADVISORY COMMITTEE TO THE CDC DIRECTOR

During the September 20–21, 2006, meeting in Atlanta of the Health Disparities Subcommittee of the Advisory Committee to the CDC Director, eight of the subcommittee members provided their input on the suggested criteria and objectives. During their discussion of the criteria, the subcommittee members addressed the following questions:

- Are the criteria clear, and if not, how could they be clarified?
- How should CDC shift the analytic framework to move to a more holistic, overarching approach to health disparities?
- How should the criteria be weighted? Are disparities paramount? Equal to?
- What other dimensions or elements of health disparities should be considered?
- What do these criteria mean to CDC's actual work?

The subcommittee members related their 25 highest priority objectives and then discussed the objectives selected as the top 10 with highest priority. The subcommittee also offered suggestions on ways in which CDC can ensure that the objectives address health disparities and recommended action items to guide the remainder of the process.

2.3 ANNUAL CONSUMER CONFERENCE OF THE NATIONAL INDIAN HEALTH BOARD[1]

Input was obtained on CDC's proposed criteria and objectives during a special session at the Annual Consumer Conference of the National Indian Health Board (NIHB) in Denver, Colorado, on October 13, 2006. The NIHB represents tribal governments operating their own healthcare delivery systems through contracts and compacts, as well as those receiving healthcare directly from the Indian Health Service (IHS). CDC is striving to work closely with Native Americans and Alaska Natives and felt that the NIHB conference offered an outstanding opportunity to hear from these important populations.

Approximately 26 NIHB conference attendees participated in the meeting. Participants first divided into small groups to discuss the proposed criteria. Participants were asked to address the following questions:

- What criteria would you use in your community when looking to prioritize CDC health objectives?
- Are there any major criteria missing?
- Are CDC's criteria clear?
- Are there any that don't belong?

The participants then broke into roundtables to discuss the objectives in the Health Protection Goals. All participants chose to discuss either the Healthy People or Healthy Places goals—none elected to participate in roundtable discussions addressing either the Healthy World or the Preparedness goals. The participants addressed the following questions:

- Which objectives are most important to you and your community and why?
- Are there any big objectives missing?
- What is the overall reaction of the group to the objectives for this area?
- Thinking about the criteria, do these objectives look consistent with those criteria?

Facilitators prepared written summaries for the small-group discussions on the criteria and on the goal areas. Participants were also invited to submit written comments.

Participants were then asked to select one-third of the objectives they considered to be of highest priority.

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[1] *Note about objectives:* Based on comments from the first meetings, the objectives were slightly modified. The Preparedness objectives were expanded from one to six; the Healthy Places objectives were collapsed from five to two. This resulted in a total of 82 objectives for review from October 13, 2006 forward.

2.4 PUBLIC ENGAGEMENT MEETINGS

The primary strategy for obtaining wider input on CDC's starter objectives was to convene a series of four public engagement meetings. Each meeting was open to anyone who wanted to attend; the majority of the worked in public health, health professional, and allied fields. The meetings were held in the following locations:

- Oakland, California (October 14)
- San Antonio, Texas (October 21)
- Boston, Massachusetts (October 21)
- Little Rock, Arkansas (November 4)

The sites were selected in mid-September jointly by representatives from CDC, Partnership for Prevention, and The Keystone Center. Criteria considered in selecting the sites were the demographic composition of the community, geographic dispersion, the presence of innovative public health programs in the community, and an expectation that the state and local health departments or an academic health center in each location would be willing to partner with CDC to convene the meeting.

Within each community, either the local health department or an academic medical center took the lead in identifying a site and assisted in identifying organizations and individuals to invite. In addition, The Keystone Center and Partnership for Prevention identified organizations to invite and partners who attended the September 19-20 meeting notified members or affiliates of the community sessions. There was no expectation that the composition of attendees at each community meeting would represent the entire community.

At each of the community meetings, participants first divided into roundtables to discuss the proposed criteria. They addressed the following questions:

- What criteria would you use in your community when looking to prioritize CDC health objectives?
- Are there any major criteria missing?
- Do the criteria seem balanced and reasonable as a set of criteria for choosing priorities?
- Are CDC's criteria clear?
- Are there any that don't belong?

Participants then dispersed to roundtables to discuss the objectives in one of the four Health Protection Goals; in Boston, participants participated in a group discussion. They addressed the following questions:

- Which objectives are most important to you and your community and why?
- Are there any big objectives missing?
- What is the overall reaction of the group to the objectives for this area?
- Thinking about the criteria, do these objectives look consistent with those criteria?

Facilitators prepared written summaries for each of the roundtable discussions on the criteria and on the objectives in each goal area. All participants were also invited to submit written comments.

In plenary session, participants were asked to select the one-third of the objectives in the goal area they discussed that they considered to be of highest priority. They were given the option of also indicating their top third in other goal areas, even if they had not participated in the roundtable discussion on those goal areas.

2.5 Session at the Annual Conference of the American Public Health Association (APHA)

Unlike the engagements discussed above, the APHA group was presented with the findings from all of the prior engagements, except for Little Rock, Arkansas, and invited to use their expertise to help interpret the findings. They were provided with tables of results from exercises to select priority objectives as well as a summary of findings and participant comments. Both comments from the floor and written comments were collected. Participants were also provided tally sheets listing the 82 objectives and were invited to select the top one-third in each goal area if they wished; seven did, and most of those suggested additional or revised objectives.

2.6 Review and Analysis of Partner and Public Input

Readers are reminded that while the various engagements provide valuable broad indications of the interests and priorities of meeting participants, the findings from individual meetings or across the meetings cannot be generalized to any larger group or population.

A major challenge for the Task Force was to ensure that each of the hundreds of comments received at the meetings was considered as the Task Force prepared its report to CDC. To assist the Task Force in reviewing the extensive input received at the meetings, Partnership for Prevention prepared summaries of each meeting that highlighted the major themes that emerged. All of these were gathered into the notebooks used at the November 13–14, 2006, meeting of the Task Force and are available on CDC's Web site at www.cdc.gov/osi/goals/workshopsPublic.html. In addition, Task Force members were given detailed meeting reports prepared by The Keystone Center that included *all* of the facilitator notes from the roundtables, all the individual comments submitted by meeting participants, and responses from priority-setting exercises.

Partnership for Prevention also prepared tables containing the results of the objective priority-selecting exercises from each locale. The tables are available on the CDC Web site listed above. Participants at the partners' meeting[2], tribal leaders' meeting, and the four community-based engagements were asked to select their top one-third of objectives for each of the goal areas in which they made selections. In addition to the tables, lists of the objectives that appeared in the top one-third at five or six of the meetings were prepared, along with lists of objectives that did not appear in the top one-third at any meeting.

[2] Because the Preparedness objectives were changed after the partners' meeting, the Preparedness objectives that appeared in the top one-third in four or five meetings were included.

The Task Force was provided with a comprehensive summary of the deliberations of the CDC Health Disparities Subcommittee that documented its selection of the top 25 priorities among the original 80 starter objectives and discussion of the top 10. A full transcript of that meeting was also provided.

During their meeting on November 13–14, 2006, Task Force members formed work groups to carefully consider all the input from the partner and public engagements. The work groups generally corresponded to the roundtable groups formed at the meetings: Healthy People, Healthy Places, Preparedness and Healthy World (one group considered both topics), and Criteria. The Task Force members identified major findings from across all the engagements; suggested ways to eliminate duplication and overlap among the objectives themselves; reviewed the objectives that were consistently identified as priorities across all or nearly all of the meetings; reviewed participant comments; and offered their expert opinions on the likely reasons for those selections as well as reasons other objectives were not selected as high priority. A similar format was used to consider the comments regarding the criteria. The details of the deliberations of each group were shared via PowerPoint presentations with the full Task Force on the second day of the meeting. Task Force members also discussed overarching issues that they had identified from the engagements.

3.0 OBJECTIVES AND CRITERIA

3.1 OVERVIEW

In addition to discussions in small groups, central to the partner and public engagement sessions were exercises for designating priorities among the 82 objectives put forth by CDC. While the limits on the rankings are pointed out throughout this section and the reasons for priority selections discussed in depth, the results are summarized briefly here.

Sixteen objectives were ranked in the top one-third by participants in five or six meetings, with nine of those selected in the top one-third at all the engagements responding to the query. An additional eight objectives were selected in the top third at four of the sessions. Objectives that tended to be broad and inclusive, such as those related to increasing numbers of people receiving comprehensive, preventive healthcare and living and working in health-enhancing environments, were most often designated high priority. Task Force members noted that this might have occurred because participants felt that the focus of more specific objectives could be subsumed under a broader objective.

Twenty-seven objectives, 33 percent of the 82, did not appear in the top one-third at any of the engagement sessions, including—somewhat surprisingly—prevention of infectious diseases among adults in the United States. It is possible participants felt this issue was covered in the objectives related to comprehensive medical and preventive care, or it may reflect a feeling that chronic disease prevention was a higher priority for this age group.

Selection of priority objectives was also influenced by who attended the various meetings. The 106 national organizations represented at the partners' meeting comprised many CDC constituencies. The majority of the approximately 150 attendees at the community-based meetings worked in the public health or the healthcare system or in a closely allied field. Many had previously worked with CDC. So while the community-based meetings were referred to as public engagements, very few of the meeting attendees were members of the general public. Section 2.0 contains additional information; and participant characteristics for each meeting can be found on CDC's Web site at www.cdc.gov/osi/goals/workshopsPublic.html.

One of the general benefits of qualitative research is that it can highlight similarities and differences among similar groups of participants in geographically dispersed areas. That certainly occurred in this project. As the engagements progressed, consistent strong themes emerged from multiple sessions, as well as concerns unique to the community or the audience.

The Task Force cautions that any attempt, including this one, to generalize from qualitative research must strictly acknowledge the limitations inherent in this process. That said, the Task Force was asked to generalize, and feels that this process provided the requisite information to permit this summary. Further, much constructive input was received to further inform this vital process.

3.2 HEALTHY PEOPLE OBJECTIVES

3.2.1 Highlights—Healthy People

- The participants in the partner and public engagements found—and Task Force members agreed—that most of the Healthy People objectives were relevant for people of all ages, and that establishing priorities among the objectives forced participants to pit one age group against another. This was especially true when health was viewed from a community perspective. Giving priority to one age group over another for achieving the same objective was difficult and, in the case of tribal leaders, viewed as culturally inappropriate.

- A continuum of care that crosses all ages and builds on healthy behavior and access to healthcare was seen as an appropriate framework for prioritizing these Healthy People objectives. The discussion in the community-based sessions consistently encouraged an integrated bio/psycho/social/environmental approach to establishing health priorities.

- The holistic, integrated approach noted above was particularly well illustrated at the tribal leaders' meeting, where it was explained that Native American culture teaches that the individual and the land are inextricably linked and at times one and the same.

- The feedback from the community-based engagements emphasized the important roles family and community play in achieving improved health outcomes. Perhaps helping to explain why the objectives designed to increase the number of people of all ages who live in social and physical environments that support their health, safety, and development were given high priority.

- The most popular objectives among participants in all engagements were those that were very broad and inclusive. Objectives intended to increase the number (of people) who live in social and physical environments that support their health, safety, and development were selected in the top one-third for four of the five age groups. This was also true for the objectives that had the intent of increasing the number (of people) who have access to and receive recommended, high quality, comprehensive, and preventive physical, mental, and dental healthcare services.

- Task Force members observed that some objectives were perhaps given a lower priority because they could be included in the broader objectives. For example, the objective to increase the number of people who have access to comprehensive healthcare services and who live in health-promoting environments could include the objectives of preventing infectious diseases and preventing injury, violence, and suicide.

- For the most part, priority was given to younger people over older ones. Overall, no objectives for adults ages 50 and over were selected in the top one-third of priorities across engagements. Because people ages 50+ account for a large and rapidly growing percentage of the population, and because the benefits of preventive services and healthy

habits in this group will result in the control and management of chronic diseases and reduction of significant disease burden, Task Force members felt this incongruity deserves careful consideration by CDC.

- In the Healthy People goal area, participants in the partners' meeting sometimes selected different priority objectives than the participants at the public engagements. For example, objective 6 (increase the numbers of infants and toddlers who live in social and physical environments that support their health, safety, and development) was included in the top one-third at four of the public meetings but was selected by only some of the partners. Objective 29 (prevent chronic diseases and consequences in the older adults and elderly) and objective 35 (improve risk and protective factors for future disease) were among the partners' top third, while they were not selected in the top grouping at any of the public engagements. When interpreting these variations, the Task Force wondered if the partners may have had a specific view of the role and capabilities of CDC or if the partners may have been more likely to support the views, interests, and priorities of their organizations than the participants at the community-based meetings.

- Some objectives are identified in one age group, but could easily apply to all age groups. Objective 20 (promote healthy activity and nutrition behaviors and prevent overweight and its consequences among adolescents) was cited as an example.

- In each of the meetings, participants stressed that mental health was missing or underemphasized. Although the Task Force noted that mental health is included in several objectives (i.e., objectives 27, 31, 32, 38, and 62) the consistent message from the public engagements was that physical and mental health are inseparably linked, influencing each other. Any comprehensive health objectives should reflect this understanding.

- Health literacy was a consistent topic in the partner and public engagements. The pervasiveness of the comments suggests a greater need for health literacy, especially in a healthcare delivery system where individual responsibility is more prominent than in the past. This is particularly important when trying to reach populations with health disparities. CDC should consider this area carefully.

3.2.2 Findings from the Objectives Priority Setting

A. Priority Objectives

Based on the priority selections from the partner and public engagements and the extensive, consistent suggestions in discussions at the engagement meetings, the Task Force members suggested combining objectives that cut across age groups and strengthen the continuum of care across all life stages. Further, they suggested including other objectives that were frequently selected as high priority and by their inclusion provide a more complete and balanced set of Healthy People objectives.

B. All Life Stages Objectives

First, the Task Force members suggest combining into a single objective the objectives 6, 13, 16, 26, and 33, all of which increase the number of people living in social and physical environments that support safety and health.

> **All Life Stages Objective 1: Increase the number of people of all ages who live in social and physical environments that support their health, safety, and development.**

Similarly, objectives 7, 14, 17, 27, and 34 could be combined into one objective: increase the number of people of all ages who receive comprehensive healthcare.

> **All Life Stages Objective 2: Increase the number of people who have access to and receive recommended, high quality, comprehensive, preventive physical, mental, and dental healthcare services.**

C. Additional High-Priority Objectives

By combining two sets of five objectives, each of which was repeated across age groups and was appropriate for all life stages, it was possible to expand the analysis of priority objectives—resulting in the following prioritized list. These were arrived at by reviewing priorities selected, the discussions at the partner and public engagements, and the expert opinion of Task Force members.

Healthy People at Every Stage of Life

All people, and especially those at greater risk of health disparities, will achieve their optimal life span with the best possible quality of health in every stage of life.

Strategic Goal: Start Strong Increase the number of infants and toddlers that have a strong start for healthy and safe lives. (Infants and toddlers, ages 0–3 years)

Objective 1: Reduce infectious diseases and other preventable conditions and their consequences among infants and toddlers.

Objective 3: Promote healthy pregnancy and birth outcomes.

Strategic Goal: Grow Safe and Strong Increase the number of children who grow up healthy, safe, and ready to learn. (Children, ages 4–11 years)

Objective 15: Improve risk and protective factors for future disease among children.

Strategic Goal: Achieve Healthy Independence Increase the number of adolescents who are prepared to be healthy, safe, independent, and productive members of society. (Adolescents, ages 12–19 years)

Objective 18: Prevent injury, violence, and suicide and their consequences among adolescents.

Objective 20: Promote healthy activities and nutrition behaviors and prevent overweight and its consequences among adolescents.

Objective 21: Prevent substance use, including tobacco, alcohol, and other drugs among adolescents.

Strategic Goal: Live a Healthy, Productive, and Satisfying Life Increase the number of adults who are healthy and able to participate fully in life activities and enter their later years with optimum health. (Adults, ages 20–49 years)

Objective 22: Prevent chronic diseases and their consequences among adults.

Strategic Goal: Live Better, Longer Increase the number of older adults and the elderly who live longer, high-quality, productive, and independent lives. (Older adults and the elderly, ages 50 and over)

Objective 29: Prevent chronic diseases and their consequences among older adults and the elderly.

Objective 32: Promote independence and optimal physical, mental, and social functioning of older adults and the elderly.

3.2.3 Task Force Comments on Healthy People Objectives

- Even after changes noted above are made, overlap with the Healthy Places objectives will need to be addressed. It is noted that the Healthy People objectives placed in All Life Stages Objective 1 above contains concepts and language similar to Healthy Places objective 38 (support the design and development of built environments that promote physical and mental health by encouraging healthy behaviors, quality of life, and social connectedness).

- Participants in all engagements felt that the age spread of 50+ was too broad and that health needs change as people age. More appropriate age groupings might be 50–64, 65– 74, and 75+. Others suggest separate groupings of 75–84 and 85+.

- Another age group concern related to adolescents. Some noted that a category of adolescents and young adults, ages 12–24, is commonly used, sometimes with subgroups within that age span.

- Another frequent comment was to consider changing the name of this category of objectives to clearly distinguish them from the Healthy People 2010 and 2020 objectives of the U.S. Department of Health and Human Services.

- The focus of some of the objectives is confusing and broadly worded, such as objective 28 (improve risk and protective factors for future disease among adults). Others have a more narrow focus, such as objective 20 (promote healthy activity and nutrition behaviors and prevent overweight and its consequences among adolescents).

- The Task Force noted that mental health, health literacy, emphasis on reducing health disparities, the importance of cultural sensitivity, and human sexuality were mentioned in the meetings as topics the participants would like to see incorporated into the objectives.

- The Task Force noted that participants in the engagement sessions frequently mentioned f health insurance as a component of access to care, although insurance coverage is not clearly incorporated into the objectives.

3.3 HEALTHY PLACES OBJECTIVES

3.3.1 Highlights—Healthy Places

- Partner and public engagement participants were generally pleased to see a formulation of objectives that included places, environmental health and safety issues, and various settings as a focus of public health action. They also commented that these objectives were not as mature or fully crafted as those in the Healthy People realm, probably because Healthy Places is a newer focus of CDC. The Task Force members were pleased to see a robust view of places and found it very much in keeping with comments received at the community level for a more holistic construct of health promotion and health protection. The Task Force encouraged continued pursuit of this important area.

- Task Force members noted that feedback from the engagements affirmed that public health is changing, moving toward an ever more holistic model that addresses people and their communities in a way that takes into account biology, psychology, social factors, and environments as risk or protective factors and potential points of intervention.

- The Task Force noted the absence of objectives related to gun safety and tobacco. It reiterated the importance of those areas to health and the particular importance of reducing gun violence to communities such as Oakland and Boston, where public engagements took place. While these topics can be politically sensitive, the Task Force acknowledges their importance to public health and recognizes that they fit within the framework of the Health Protection Goals.

- Overlap between the Healthy Places objectives and the Healthy People objectives should be eliminated. If clear distinctions can be drawn, the objectives can be appropriately re-worded. If not, they should be eliminated from one or the other Health Protection Goals.

- Objective 42—improve the social determinants of health such as poverty, discrimination, and poor education among communities with excess burden and risk—caused much discussion during engagements and among Task Force members. CDC staff explained that this had begun as an objective reflecting environmental justice that shows, for example, that industrial plants and toxic waste sites are frequently located in or near lower socioeconomic status areas, thus increasing disease risks in those areas. Gradually this objective evolved into *the* social determinants objective, drawing high priority in all locales. Meeting participants expressed confusion over a single objective dealing with social determinants, a criterion

related to excess risk in communities or populations, and comments saying health disparities will be addressed throughout the objectives. Task Force members feel strongly that exactly how disparities will be addressed within the CDC objectives must be clarified.

- Regarding social determinants, Task Force members wanted to commend for consideration to the goal team leaders a suggestion received during the APHA session: Could CDC, using existing data from multiple sources, pull together a data "picture" of the social factors related to health that might include data related to high school graduation rates, income gaps, poverty rates, access to and costs of college, rates of people without health insurance, levels of homelessness, safety or crime data, etc.? CDC would not need to collect this data but could pull the sources together and derive meaningful reporting at the state, city, or county levels of the key social factors associated with health status.

3.3.2 Findings from the Objectives Priority Setting

A. Priority Objectives

The following Healthy Places objectives were rated among the top one-third in five or six of the engagements, their importance were supported through discussion and commentary, and the Task Force members concurred that these objectives are of high priority.

Healthy People in Healthy Places

The places where people live, work, learn, and play will protect and promote their health and safety, especially those at greater risk of health disparities.

Strategic Goal: Healthy Communities Increase the number of communities that protect and promote health and safety and prevent illness and injury.

Objective 36: Increase the number of communities that have high-quality air, water, food, and waste disposal and are safe from toxic, infectious, and other hazards.

Objective 38: Support the design and development of built environments that promote physical and mental health by encouraging healthy behaviors, quality of life, and social connectedness.

Objective 39: Support equitable access to and receipt of essential health promotion, health education, public health, and medical services.

Objective 42: Improve the social determinants of health such as poverty, discrimination, and poor education among communities with excess burden and risk.

Strategic Goal: Healthy Healthcare Settings Increase the number of healthcare settings that provide safe, effective, and satisfying patient care.

Objective 49: Increase the delivery of good-quality prevention and screening services in healthcare settings.

Strategic Goal: Healthy Schools Increase the number of schools that protect and promote health, safety, and development of all students, and protect and promote health and safety of all staff.

Objective 60: Increase the number of schools that promote the health and safety of students, their families, and school staff by implementing a comprehensive program of instruction, programs, policies, and services.

Objective 62: Increase the number of schools that have a safe, healthy, and accessible social, psychological, emotional, and physical environment.

B. Additional Priority Objectives

In addition to the objectives listed above, the Task Force, for reasons noted below, commends the following additional objectives for consideration as high priority.

Strategic Goal: Healthy Communities Increase the number of communities that protect and promote health and safety and prevent illness and injury.

Objective 40: Understand and reduce the negative health consequences of climate change.

Task Force members suggest that CDC be vigilant about the potential consequences of climate change on health, which might include increases in natural disasters, rapid shifts of populations, changes in the geographic ranges of infectious diseases, increases in worldwide hunger or drought, or other unanticipated effects. It is also clear that CDC must work in concert with other key agencies and organizations to effectively address these emerging health concerns. (*Note*: The Healthy World work group also addressed climate change and global warming.)

Strategic Goal: Healthy Travel and Recreation Increase the numbers of environments that enhance health and prevent illness and injury during travel and recreation.

Objective 46: Promote injury-free travel and recreation.

The leading cause of unintentional injury and death among people ages 1 to 44 worldwide is injury, with motor vehicle crashes causing the majority of those unintentional injuries and deaths. This appears to be the objective most closely aligned with that data and is therefore recommended for consideration, but with revised wording, discussed in section 3.3.3, to incorporate the notion of "transportation" as well as "travel and recreation."

Strategic Goal: Healthy Workplaces Promote and protect the health and safety of people who work by preventing workplace-related fatalities, illnesses, injuries, and personal health risks.

Objective 63: Reduce the number of workers that are killed, injured, or made ill on the job.

Task Force members felt strongly that because so much time is spent in the workplace and because it is the locale of many effective health protection and health promotion interventions, it should be represented among the high-priority objectives. They also noted that only a few people representing concerns of blue collar and service workers attended the sessions and, if they had, the workplace objectives might have risen in importance.

3.3.3 Task Force Comments on Healthy Places Objectives

- The most frequent comment at partner and public engagements was about the excessive overlap between the Healthy People and Healthy Places objectives. The overlap should be eliminated.

- The perceived overlap arises from the similar wording used in the objectives in the two goal areas. Task Force members feel strongly that objectives in the two sections must be clearly distinguishable from each other. Following are the areas of overlap in the Healthy People and Healthy Places objectives that, in the opinion of the Task Force, must be addressed:

  - Healthy Places objectives 38, 48, and 62 support built environments, travel and recreation, and schools, respectively, conducive to health, quality of life, and social connectedness. Healthy People objectives 6, 13, 16, 26, and 33 relate to increasing the numbers of people who live, work, and play in social and physical environments conducive to health.
  - Healthy Places objectives 49, 50, and 53 strive to increase high-quality preventive and screening services. In Healthy People, each life stage lists an objective related to either comprehensive medical care or recommended preventive service, although the wording of each varies (objectives 7, 14, 17, 27, and 34).
  - In Healthy Places, several objectives relate to safety and violence and injury prevention (36, 41, 43, 44, 45, 46, 56, and 53). In Healthy People, objectives 2, 11, 18, 24, and 31 address prevention of violence and injury.

- The strategic goal Healthy Travel and Recreation was perceived by the partners and the public as referring to vacation travel only, and not travel to and from school or work or around the community. It did not appear to address transportation-related work, such as that of bus drivers, pilots, or truck drivers. A suggested change is to call the strategic goal "Healthy Transportation, Travel, and Recreation."

- Objectives in the strategic goal Healthy Communities were popular with the partners and the public, who indicated support for an elevated focus on communities. "Community" can be difficult to define, however. Programs tend to be funded by geopolitical boundaries, but people may feel a sense of community in their neighborhood, workplace, place of worship, child's school, or other group to which they belong. Others may reside in a community but not have the feeling of being part of a larger group. If community becomes a focus, defining what is meant will be important.

- Task Force members lamented that the objectives related to the strategic goal Healthy Institutions did not fare well when partners and community members selected priorities.

They feel strongly this is a reflection of the experience and interests of people attending the sessions and in no way should be construed that these objectives lack importance.

  - They also noted that many engagement participants felt that nursing homes and other long-term care facilities should be addressed in this strategic goal or Healthy Healthcare Settings. Others suggested that skilled nursing and rehabilitation facilities falling under health care and other long-term care facilities be placed under Healthy Institutions.
  - In addition, they suggested that daycare settings be included in the strategic goal Healthy Schools instead of Healthy Institutions because daycare issues may be more aligned with those of schools.
  - Whatever approach is taken, CDC should make clear exactly which institutions are included in this set of objectives.

- Meeting participants and Task Force members, appreciating that access to medical care is alluded to in several objectives, asked why there is not a clear objective related to access to healthcare that unambiguously addresses the lack of access to and/or availability of consistent care.

- Task Force members commented that it is difficult to discern where continuing attention to smoke-free settings appears in the objectives.

3.4 PREPAREDNESS OBJECTIVES

3.4.1 Highlights—Preparedness

- The events that are envisioned in the Preparedness goal area and in the objectives often encompass far more than health. CDC needs to be able to ensure that health concerns fit within a larger preparedness system and are fully addressed during a disaster. CDC roles and responsibilities within the emergency management framework (such as the National Response Plans) should be focused on ensuring that health issues are fully incorporated into preparedness and response systems.

- Many participants at the community-based engagement meetings commented that during an event, preparedness is primarily a state and local responsibility, while CDC's primary role is to help build the foundation that can be the basis for disaster response efforts. A clear delineation of CDC's role is important, along with clarity of the roles CDC can play as state and local health agencies develop and refine response capabilities.

- Participants at all engagements consistently ranked the objective 65 (all hazards) as a high priority. This suggests a view that preparedness needs to be incorporated into the ongoing work of public health. Tools, systems, and capacities should not be created uniquely for emergency response to large-scale events. Rather, the same capacity that responds to issues on an ongoing basis should scale up to address larger events or scenarios.

- The Task Force noted that an alternate way of framing priorities in the Preparedness goal area could be drawn from public expectations about disaster preparedness and response. Specifically, what failures during an event would the public not tolerate? What should the

outcomes be? Using this framework, CDC would need to carefully balance its strengths with public expectations.

3.4.2 Findings from the Objectives Priority Setting

Priority Objectives

The participants at the tribal leaders' meeting and at the four community-based meetings were very consistent in the way they ranked the six objectives.[3] Two of the six objectives clearly emerged as the highest priority. Objective 65 (all hazards) was included in the top one-third of Preparedness priority objectives at each meeting. Respondents uniformly appeared to view an all-hazards approach as underlying the response for any and all events that necessitate a public health response. Focusing first on an all hazards capacity ensures the base or foundation on which responses to different disaster scenarios should be built.

Objective 68 (emerging infectious disease) was identified as a high-priority Preparedness objective at every meeting but one (Boston). The consistently high ranking given to this objective appears to recognize CDC's strength in infectious disease control and its leadership in this area. The priority given to this issue also addresses capacity that is applicable to pandemic influenza and aspects of terrorism.

Overarching Goal #3:
People Prepared for Emerging Health Threats
CDC's preparedness activities—spanning the spectrum from mental health to environmental health—will help in safeguarding lives and responding to threats.

> **Objective 65:** All Hazards: People in all communities will be protected from any emerging health threat using an all-hazards approach to preparedness.
>
> **Objective 68:** Emerging Infectious Disease: People in all communities will be protected from emerging and new infectious diseases like SARS, West Nile virus, and *E. coli* 157.

3.4.3 Task Force Comments on the Preparedness Objectives

- Protecting people in all communities from pandemic flu was the only other objective placed in the top one-third of Preparedness objectives at any of the meetings. The objectives that consistently ranked lowest in the Preparedness goal area addressed natural disasters, bioterrorism or other terrorism, and occupational disasters—objectives that are likely to be managed by entities in multiple sectors. Health is one of many issues that would be addressed, but in many cases it may be a secondary or post-event issue.

[3] The initial version of the starter objectives included only one Preparedness objective—all hazards. Thus, participants at the partners' meeting and at the meeting of the Health Disparities Committee did not rank objectives within this goal area, but they did select all hazards as a priority among the 80 objectives put forth at that time. CDC expanded this goal area prior to the tribal leaders meeting and the community engagement meetings to include the six objectives.

- As with many of the other goal areas, the Preparedness goal area included at least one overarching objective—the all hazards objective—that was capable of subsuming most, perhaps even all, of the other objectives. This allowed participants to capture multiple disaster areas with a single "vote." As noted above, though, it also was consistent with the recognition that a solid foundation in preparedness is necessary to successfully address a wide range of disasters that may arise.

- The objectives in the Preparedness goal area were framed very differently than in the other goal areas. Other objectives are often framed in terms of incremental measures, such as "increase," "improve," or "reduce." In contrast, the Preparedness objectives, all of which state that people in all communities will be protected from a particular hazard, are framed as goal statements and rely on "binary" measures of success. The lack of more precise measures of success or failure may add to current problems associated with the inability to measure preparedness and progress under cooperative agreements in this area. Task Force members noted that CDC cannot *protect* people from all hazards, but rather can ensure that comprehensive emergency response systems are in place and public health capacity is sufficient to address health issues in all communities.

- While chemical, nuclear, and radiological disasters were not specifically addressed in the Preparedness objectives, they could very easily be encompassed in the all-hazards objective or in the terrorism objective.

3.5 HEALTHY WORLD OBJECTIVES

3.5.1 Highlights—Healthy World

- Participants at the partner and public engagements generally did not have as much experience and interest in Healthy World goal areas as they did in the Healthy People and Healthy Places goal areas. This may be one reason that the Healthy World objectives were generally ranked low when individuals voted on their priorities across all objectives. In addition, at the community meetings, a very small number of people participated in the roundtable discussions on global health. Thus, the selection of priorities within the Healthy World goal area must be interpreted with extreme caution.

- The Task Force noted that the results might have been significantly different if representatives from other sectors had participated in the engagements. For example, had representatives of the business sector participated broadly, issues that potentially have an economic impact on companies might have rated higher. Occupational injuries were cited as one example.

- Participants at the San Antonio meeting pointed out that border health was not included among the Healthy World objectives, and participants in Little Rock discussed health issues in their community among immigrant populations. The Task Force noted that it might be more appropriate to think more broadly about issues related to immigration and multinational populations. Border health issues can be thought of as a subset of this larger issue. The Task Force recognized that, with border health issues specifically, CDC's role

versus states' roles is not always clear. For example, some states have begun dealing directly with the Mexican government to address important border health issues.

- This also raises the larger issue of whether the nation's global health agenda and domestic health agenda will become more closely aligned over time. The Task Force members questioned whether at some point in the future CDC will need to consider merging its international and domestic health goals and objectives.

- Some participants at the partner and public meetings commented that the objectives were too American-centric, pointing specifically to language in the strategic goal Global Health Protection that says "Americans at home and abroad will be protected…" with no mention of any other people on the globe.

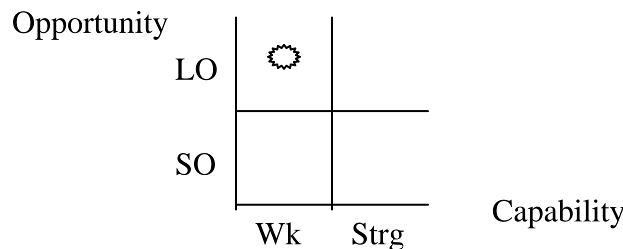
- Global Health Diplomacy—one of the three strategic goal areas—generates conflicting reactions. Some believe that health improvement is a noble goal and should not be diminished in any way by using it as a tool for international diplomacy. Others believe that since health improvement is such a laudable goal, assisting other countries to address health issues is a valuable tool for building relationships around the world.

Global Warming: An Opportunity?

Although global warming was not included in the Healthy World starter objectives, a number of participants at the public and partner engagement meetings identified it as an important global health issue. This suggests that there is considerable interest in having CDC engage in this issue and to legitimize climate change as a public health issue. While the potential future impact on health of climate change is large, CDC has done relatively little in the area and is not considered the lead agency. (*Please note*: Understanding climate change and reducing its health consequences is an objective in the Healthy Places goal area; it was designated a high-priority by the work group on Healthy Places.)

Talk of global warming gave rise to discussions among the Task Force about other ways to identify high-priority issues in addition to applying the four suggested criteria. Issues can also be characterized by whether they present a large opportunity (LO) or small opportunity (SO) to improve health, and whether CDC's current ability to strengthen the issue is weak (Wk) or strong (Strg). This can be visualized in the matrix below.

CDC Decision/Investment Matrix



Climate change represents an issue where an opportunity likely exists to address health impact, but where CDC's experience and competencies are limited. Thus, this is an example of an issue where CDC needs additional work before it is ready to bring a program "to market." For example, more research likely needs to be done, people need to be trained to address the issue, and policies and programs need to be tested. Still, the fact that CDC's current ability to address an issue is limited does not mean that the issue should be considered a low priority for the agency.

Also, climate change is an example of an issue that represents an opportunity for CDC to form broad-based partnerships. In fact, one of the greatest challenges spanning the broad spectrum of global health issues is the need to partner with numerous organizations to improve health outcomes. Establishing global surveillance systems was cited as another example of an area in which partnerships are essential.

3.5.2 Findings from the Objectives Priority Setting

Priority Objectives

In the Healthy World discussions at the partner and public engagement events, two of the twelve Healthy World objectives consistently emerged as high priorities. One of these objectives—prevent infectious diseases and their consequences—was identified as a high-priority objective at the partners' meeting, at the meeting of the Health Disparities Subcommittee, at the tribal leaders' meeting, and at each of the four community meetings. The other objective—increase global capacity to detect, verify, respond to, contain, and prevent emergent health threats—was identified as a high-priority objective at each meeting except for the Boston community meeting.

Overarching Goal #4:
Healthy People in a Healthy World:

People around the world will live safer, healthier, and longer lives through health promotion, health protection, and health diplomacy.

Strategic Goal: Global Health Promotion Global health will improve by sharing knowledge, tools, and other resources with people and partners around the world.

Objective 71: Prevent infectious diseases and their consequences.

Strategic Goal: Global Health Protection Americans at home and abroad will be protected from health threats through a transnational prevention, detection, and response network.

Objective 82: Increase global capacity to detect, verify, respond to, contain, and prevent emergent health threats.

Two other objectives also ranked highly at the partner and community-based meetings, and the Task Force members commend them for consideration as high priorities:

> **Objective 72:** Reduce child mortality by addressing issues such as acute respiratory infections, diarrheal disease, improved nutrition, and safe and sustainable sources of drinking water worldwide.
>
> **Objective 79:** Develop sustainable public health capacity.

Several factors may help explain why meeting participants felt that the objectives related to infectious disease and to emergent health threats should be given the highest priority among the Healthy World objectives. First, the emphasis on infectious disease and emergent threats is consistent with the participants' understanding of CDC's strengths and its traditional public health role. In addition, enlightened self-interest may have influenced participants' choices. Controlling communicable diseases globally and protecting against emergent threats are public health objectives that, if achieved, would benefit Americans.

3.5.3 Task Force Comments on Healthy World Objectives

- The Task Force noted that the construct of the Healthy World goal area is somewhat awkward in at least two ways. First, since CDC's four overarching goals are referred to as CDC's Health Protection Goals, it makes little sense to have a single strategic goal area within the Healthy World goal called Global Health Protection. What do the other two Healthy World strategic goal areas represent if they are not health protection objectives?

- A second issue identified by the Task Force is that confusion exists around the definition of the strategic goal Global Health Diplomacy. This may be a phrase that is readily understood in diplomatic circles, but it is not commonly used in the public health community. Each of the strategic goal area categories should be readily understandable. In addition, the Task Force was unclear why the objective to reduce maternal mortality was included in Global Health Diplomacy, while the objective to reduce child mortality was considered under Global Health Promotion. (*Note*: A Task Force member explained that reducing child mortality is primarily related to prevention and treatment of infectious diseases, while preventing maternal mortality has more to do with improving overall healthcare capacity and availability.) The explanation is clear, but the objectives as written cause confusion and need to be clarified.

- Within the Healthy World goal area, CDC has done a good job of ensuring that each objective is discrete (i.e., there is very little overlap among the objectives). However, some of the functions, such as establishing and/or maintaining surveillance systems, will play a role in accomplishing multiple objectives.

3.6 CRITERIA

The following four criteria for the starter objectives (which can be found on CDC's Web site at www.cdc.gov/osi/goals/workshopsPublic.html) were presented and discussed at each of the eight public engagements:

1. Why is this health issue important?
2. How are different groups or communities affected?
3. Is it feasible to make progress on the objective today, or does it present a research opportunity?
4. Is the objective consistent with CDC's mission, core values, and interests?

The lively discussion on the criteria generated a lot of useful input on process improvements (both implicit and explicit), the content, and other constructive criticisms. Generally, participants in the various engagements felt that if CDC were going to have criteria for the starter objectives, it had identified the correct set to use, although significant questions on application, budget, and accountability remain.

3.6.1 Highlights—Criteria

- The criteria's frame of reference is not clearly established. It is unclear whether the criteria will be determined from CDC's view or if they are being considered with broader needs in mind. It is also unclear if the criteria should be assessed at the domestic or the global level.

- There is a lack of clarity by CDC on how the criteria will be applied, and the following questions arose in regard to this ambiguity:

    - How will the criteria be used?
    - Who will use the criteria?
    - At what point in the process will the criteria be used?
    - How will the criteria measures be updated?

  Despite the numerous quandaries that were pointed out, the engagement process does not tell CDC how to apply the criteria to develop priorities and objectives.

- Participants wondered if the criteria are individual entities or if they interact with one another. Before the criteria are applied to the objectives, it should be determined if and how they interact with one another and if some criteria should be given higher priority than others. If some are given higher priority, it must be determined how the criteria will be weighted and if this weighting will be consistent throughout the objectives or if the weighting will be objective-specific.

- Participants noted, and the Task Force members concurred, that how these or revised criteria will be used in the future to assess additional objectives or program areas is unclear.

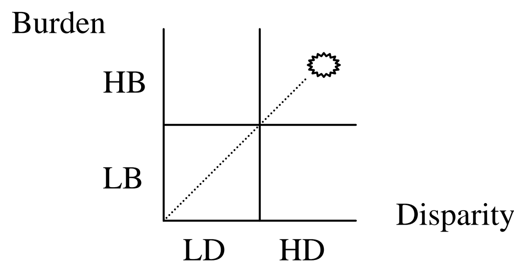
- The criteria should be scalable rather than absolute. To accomplish this, the interrogative word in each criterion should be changed to *how*. This is not to suggest that the measures must be numeric; they can also be highs and lows (see the matrix below).

- Underlying the discussion on criteria, participants were really wondering whether or not, once the criteria is applied, they will result in the correct set of objectives—a set that has face

validity and makes sense to multiple audiences. CDC should consider whether the criteria will yield an appropriate portfolio of highest priority objectives.

- Many participants wanted each criterion to be applied at the community level and to consider the community's values (e.g., holism). This is to say that the burden should be measured at the local level and then crossed with the community's values when ordering the objectives. This would, of course, imply that the set of highest priority objectives would vary by community. The participants requested that flexible funding be given to communities to implement their unique set of objectives. Moreover, participants wanted implementation activities to be community-specific to ensure sustainability at the community level. As the Goal Action Plans are being developed, the goal team leaders may find value in partnering with local and community organizations to develop action plans that can be implemented and sustained at the community level.

- The Health Disparities Subcommittee produced a functional framework for sequencing the application of the criteria. This concept is just one of the examples of the useful information that came out of this discussion. In the structure, diagrammed below, the subcommittee developed a matrix that considers low burden (LB) and high burden (HB), low disparity (LD) and high disparity (HD). HD/HB objectives will be given the highest priority in the criteria ranking. Multiple matrices can be used with different scales and then layered to consider all of the necessary criteria. This framework suggests a working algorithm that CDC can use to apply the criteria.



- In order for CDC to remain transparent throughout the entire prioritization process, the selection process should be unambiguously stated. The criteria were developed to help prioritize the objectives; however, it should be decided how much the criteria will affect the final placement of the objective. Additionally, CDC should clarify when, how, and by whom criteria will be applied to the objectives.

3.6.2 Findings from Discussions of Criteria in Engagements and by Task Force Members

In the partner and public input, there are several findings that really characterize the discussion on criteria. The application of the criteria, the importance of local values and concerns, and leveraging partnerships were mentioned multiple times by participants across several engagement meetings, and each has practical implications for CDC and its goal-setting process.

A. Why is this health issue important?

- As CDC explains, this criterion is an assessment of burden and risks or threats. While the concept of assessing burden was seen as an appropriate criterion, the word "burden" did not resonate with participants at the public engagements. "Burden" was seen as a pejorative term that is culturally insensitive because it suggests that the person with a health concern is an imposition on the community. Though the participants did not offer a clear alternative, they did suggest stating it positively, highlighting the opportunity for prevention rather than the prevention of burden. Many participants felt that prevention and preventable burden were underemphasized in the criterion; changing "burden" to "prevention" may address these concerns while maintaining the spirit of the criterion.

- There is also a lack of clarity surrounding some terms. For example, participants did not know if burden referred to current burden or the potential future burden. Burden as used appears to apply to severity, but the urgency of addressing an issue and the growth potential of the issue also need to be captured.

- Participants offered suggestions on how this criterion should be balanced with others. Many believed traditional measures of health burden should be weighted differently so that those measures influence the selection of priorities more than other factors. Other participants thought that social determinants should be risks themselves or health disparities should be the measure of burden. In the latter suggestion, however, CDC would have to determine how to address a situation where there is a high incidence of disparity concentrated in a small group versus less sizable disparities that are found among a larger number of people.

- One of the purposes of CDC developing criteria is to remain transparent in its objective selection process. In this effort, it is important that the outcome be measurable. Participants agreed with this point but warned against a slavish devotion to empirical evidence because there are burdens that cannot be quantified. The absence of data or their immeasurability should not exclude them from consideration. Burdens such as the impact of being exposed to prejudice, the stress of living in poverty, and the stress of being part of a minority population are all examples where the compelling argument is not data driven.

B. How are the different groups and communities affected?

- This criterion is really an assessment of health disparities, and CDC supplied a list of population characteristics by which disparities will be defined. Participants suggested changing the wording of one of the populations, "disability status," to "functional limitations" because "disability" is considered disparaging by some. Participants also suggested adding "country of origin" to "racial and ethnicity," "immigrant status," and "housing status." The list avoids the issue of social preference and lifestyles by shying away from the explicit mention of populations defined by sexual orientation, though it does include "risks related to sex and gender."

- Although health disparities account for a large part of this criterion, participants said that there are other factors that influence health impact in different groups and communities, such as local values and health needs.

- In considering local values and cultural competence, CDC should use culturally appropriate communication. CDC should also note the difference between cultural competency (what one does) and culture (how one lives).

C. Is it feasible to make progress on the objective today, or does it present a research opportunity?

- Of the four criteria, this one seems to engender the most confusion about what exactly was intended; different participants read it differently. The general sentiment was that research should not be included in this criterion because it created a false dichotomy in that it is unclear what should happen if the objective addresses a high burden but little is known about it. Including research with feasibility also confuses potential evaluation measures. Another suggestion was to make research its own criterion.

- Many participants were confused by this criterion due to its wording and format. Although participants thought that all of the criteria should be measurable, it was suggested that this criterion specifically be reworded as "How feasible is it…" so that it is scalable. Participants also felt that the criterion should not be an "either/or."

- In addition to the listed elements to consider, participants stressed the need to include political feasibility, whether or not progress can realistically be made in the area, the existence of an effective intervention, and whether or not the implementation activities are sustainable.

- Considering the issue of research, participants, especially those at the tribal leaders meeting, emphasized the need for applied research and interventions that actually improve health rather than basic research unaccompanied by implementation activities. The tribal leaders said that Native Americans have been over studied but have seen very little health improvement as a result.

D. Is the objective consistent with CDC's mission, core values, and interests?

- This was a dichotomous discussion. Some participants voiced feelings that CDC can impact any area and can always play a role, while others felt that this question was inappropriate as a criterion because CDC should not put forth objectives that do not already meet this criterion. Both of these concepts could be captured if the criterion were made scalable by rewording the question to read "How consistent" rather than "is the objective consistent."

- The issue of partnership with other agencies and organizations (on the federal, state, local, and tribal levels) was mentioned frequently, but there was a particularly great deal of discussion concerning this criterion during which participants expressed a need to add "and ability to leverage partnerships." Mental health and substance abuse as well as poverty and lack of access to healthcare were recurring themes. With this addition, CDC can balance between areas in which it has clear authority and accountability, those that are only within its sphere of influence, and those in which others are clearly in the lead and in which CDC has a part to play. In this sense, CDC's role expands as a convener, coordinator, and valued

participant, not just a programmatic actor. If CDC can always play a role appropriate to its mission and mandate, this criterion may be unnecessary.

4.0 OVERARCHING ISSUES

4.1 PUBLIC HEALTH INFRASTRUCTURE

Many participants at the partner and public engagements expressed concerns that the objectives do not address the need to strengthen the public health infrastructure. Although participants did not doubt CDC's commitment to building a strong infrastructure, they were concerned that an unintended consequence of not addressing this explicitly would be a reduced emphasis on the public health infrastructure.

The public health infrastructure includes a well-trained public health workforce; the data and communications systems needed to carry out important public health functions; and advanced organizational and systems capacities. This last category includes updated laws, policies, and regulations and modern facilities and laboratories, especially those that support surveillance and epidemiological investigation.

The Task Force recognizes that the ability to reach objectives will be hindered by deficiencies in the public health infrastructure. One local health officer proposed a new goal—namely, that all individuals will be served by a fully staffed, fully operational public health agency. This goal would address such issues as the workforce and fragmentation of programs and services. The Task Force did not take a position on this recommendation but believes that it is important for CDC to make explicit its plans for strengthening the public health infrastructure, especially at the state and local levels.

It is worth noting that CDC is developing its own Organizational Excellence Assessment (OEA) tool to assess the agency's performance. CDC understands that public health results are the most important measure of CDC's success. In order to improve the agency's performance, however, CDC is developing internal performance objectives. In essence, the OEA objectives aim to improve CDC's internal infrastructure. CDC hopes that the OEA will serve as a model assessment tool for state and local health departments, although it remains to be seen whether state and local agencies will find the tool helpful.

4.2 HEALTH DISPARITIES

CDC, the Task Force, representatives from partner organizations, and the public engagement attendees all agree that health disparities and health equity are important issues that must be continuously considered throughout the process of selecting the highest priority objectives and during the development and implementation of the Goal Action Plans.

There was a great deal of confusion about how health disparities will be addressed. The Task Force understands that CDC will address disparities by requiring dedicated resources, actions, and measurement that are systematically and clearly identified in all of the Goal Action Plans; however, this proposal was not clearly explained at the public engagements, and most participants did not seem to be aware of CDC's plan to consistently address health disparities throughout the entire Health Protection Goals process. Meeting participants expressed frustration and confusion over the discrepancies between a single objective dealing with objective 42 (social determinants), criterion B (How are the different groups and communities affected?), which is really an assessment of health

disparities, and comments made during the meetings health disparities will be systematically addressed throughout the objectives.

The Task Force also understands that CDC's Health Disparities Subcommittee has met to discuss and make specific recommendations on the health protection criteria and objectives.

Engagement participants provided very little feedback on whether or not CDC's proposed approach to health disparities is appropriate. The Health Disparities Subcommittee did say that if the approach is rigorously applied it could be effective, but still recommended that the Goal Action Plans include specific action items to address different populations with different needs. CDC's plan was not clearly communicated in the eight engagements, although participants stressed the importance of addressing health disparities and conveyed the expectation that CDC will be more involved than it is now in dealing with the root causes of health disparities and inequities.

The Health Disparities Subcommittee offered numerous helpful recommendations. It recommended that CDC add "social determinants of health" as an explicit bullet under "Risk or Threat." As mentioned earlier, many of the participants at the community-based meetings emphasized the importance of combating issues that are at the source of health disparities, such as education, poverty, employment, and housing. While exceedingly important, these issues are beyond the scope of CDC's mission. The subcommittee recommends that CDC support the mission of key partners that deal with these issues. (The importance of partnerships will be discussed in greater detail in a later section.)

Despite CDC considering health disparities in the formation of the Goal Action Plans and enlisting the advice of the Health Disparities Subcommittee, concern remains that if there is no superordinate and clear recognition of health disparities, CDC's ability to address and measure health impact in populations disproportionately affected by health burdens will continue to languish. CDC should also consider clearly indicating how social determinants will be addressed.

4.3 HEALTH LITERACY

With fewer than one in six adults having "proficient" health literacy (U.S. Department of Education, National Assessment of Adult Literacy, 2003), and with health literacy's association with health status documented in several recent studies, participants in all engagements urged CDC to seriously examine leadership opportunities to address health literacy issues. The issue is well-documented, and several groups have undertaken collaborative activities. The Task Force suggests that CDC work in concert with existing efforts to determine the most effective role the agency can play in increasing health literacy among all segments of the population and disseminating effective strategies and interventions widely within the public health community.

4.4 HOLISTIC APPROACH TO HEALTH

Participants at the partner and public engagement events often raised the issue of whether the objectives reinforced viewing individuals holistically, not just in terms of, for example, their specific risk factor, disease, or age group. While people who raised this issue felt that viewing people as holistically as possible was an appealing way to view health, they also recognized the difficulty in formulating objectives that will guide programmatic activities that focus on the whole person.

While many people advocated for a holistic approach to health, this was a very broad concept that encompassed many themes. It often included what some Task Force members referred to as bio/psycho/social/environmental interactions that influence a person's health. This suggested that some of the objectives were framed too narrowly. For example, many objectives focus on positive health outcomes among children, but participants noted that interventions often need to target the entire family, not just the child. Some participants raised the issue of cultural competence in that approaches to health improvement need to take account of the cultural environments and norms that shape people's lives.

Others who raised the issue of holistic health appeared to be referring to the fragmented, categorical way services are often funded or delivered, especially at the local level. This fragmentation often results from the restrictions imposed by various funding agencies. For example, an individual who presents at an HIV clinic may have to go elsewhere for a flu shot and somewhere else to address environmental hazards in the home. The public health and healthcare systems are often structured to address specific health problems but not to address the individual's spectrum of healthcare needs. Ironically, one of the purposes of CDC's proposed objectives is to break down the silos that inhibit collaboration and integration of programs across various CDC units. Nevertheless, participants at the engagement events were unclear about how the objectives would achieve this goal.

Partners and the public frequently noted that the Healthy Places objectives that focused on communities seemed to embody a holistic approach to health. These objectives implicitly encompass all of the key biological, psychological, social, and environmental forces that affect health. In addition, participants noted that the environment (e.g., the home, the workplace) is inextricably tied to health. Thus, some participants felt that having separate objectives for Healthy People and Healthy Places may hamper CDC's ability to view health in a holistic manner.

The preference for holistic approaches may have made it difficult for some people to prioritize those objectives that segmented people by age groups or that focused on specific places.

4.5 INTEGRATION WITH OTHER PRIORITIZATION EFFORTS

There are other important public health prioritization efforts, both internal and external to CDC. So many, in fact, that the Task Force, attendees at public engagements, and partners frequently asked how the Health Protection Goals initiative will be integrated with the various other priority-setting processes. Within CDC, other related prioritization activities include the Research Guide, the Community Guide, and the Organizational Excellence Assessment. The Task Force understands that the Research Guide identifies opportunities for research but is not itself a research agenda. Rather, CDC will be challenged to develop a research agenda that responds to and supports the goals and prioritized objectives.

Of particular concern to all is the confusion between CDC's objectives and other national objective-setting programs within the U.S. Department of Health and Human Services—Healthy People 2010 and 2020 in particular. The Task Force recognizes that CDC sought to clarify that relationship as the engagements progressed, but confusion persists. Consistent and continuing efforts will be essential, especially because Healthy People is so widely integrated within the broad public health community. It is interesting to note that CDC's goal-setting process strongly echoes the original framework of *Healthy People: The Surgeon General's Report on Health Promotion and Disease*

Prevention (1979), which set targets for healthy infants, healthy children, healthy adolescents and young adults, healthy adults, and healthy older adults, along with preventive health services, health protection, and health promotion goals. The Task Force encourages CDC to continue to work with DHHS to align CDC's goals with DHHS's Healthy People objectives and to clarify the relationship between the two efforts.

Finally, there are goals set by international health organizations, such as the Millennium Development Goals, WHO global and regional goals for disease eradication, and other objective-setting processes with which CDC's global health activities should align if possible.

Drawing clear correlations among these parallel and related efforts can prevent these initiatives from moving forward in isolation and can augment the development of workable prioritized objectives for the Health Protection Goals. In order to do so, the way these efforts are aligned needs to be made clear.

4.6 PURPOSE OF THE PRIORITIZATION PROCESS

In order for the entire prioritization process to be viewed as credible, the rationale for an objectives selection as a low- or high-priority objective should be unambiguously stated, and the terms "high priority" and "low priority" should be clearly defined. CDC must address both items for itself, but the Task Force heard questions and made observations that may inform the agency's thinking in this endeavor.

In regard to the process of selecting priority objectives, two important items must be considered: the criteria and the input from the eight partner and public meetings. The criteria were developed to help prioritize the objectives; however, CDC should decide how much the criteria will affect the final prioritization of the objectives. CDC must also decide how to apply the criteria at the crosswalk between federal priorities and state and local priorities. There are numerous reasons certain objectives were ranked low—for example, due to an artifact of the question (e.g., overlap with other objectives causing split votes) or a misunderstanding of the process. Though the process was imperfect, CDC may still use the collected data to supplement the application of the criteria and to inform the entire process.

One last issue to consider is whether CDC is concerned with achieving a balanced portfolio of objectives. If so, variability and balance may be considered when selecting the highest priority objectives. All of these issues must be combined to develop a set of objectives that have adequate breadth and reflect the values and priorities of the public, the variation of values in different communities, and health needs.

As in any prioritization process, some objectives will receive highest priority and others will receive the lowest. In this particular endeavor, it is unclear how many priorities will be selected, whether prioritization is being used for exclusion or for emphasis, and what will happen to the objectives that are given lower priority. It is important to note that at the partner and public meetings, participants were informed that lower priority objectives would not be ignored. CDC may consider writing a clear statement on the process that addresses some of these issues.

The statement has been made from the outset that CDC's budget will be tied to the prioritized objectives. Without a clear plan and timeline for how this will occur, considerable unrest

will persist within stakeholder organizations because they are uncertain of the relevance of CDC's process to funding issues that affect them. Thus, developing this plan and timeline should be a priority of the highest level for the agency. That said, the Task Force recognizes that the majority of the CDC's budget—approximately $5 billion—is distributed to the states through cooperative agreements, so if the budget alignment changes, it must occur through cooperative agreements with states and localities.

4.7 ARCHITECTURE OF THE OBJECTIVES

The Task Force observed that the objective-setting process was imperfect and the prioritization process remains shrouded by uncertainty. There is no uniform format for the objectives, so some have an advantage over others because of their semantic characteristics or because they refer to broad topics and encompass more issues. It is unclear what it means for an objective to be given low priority versus high priority and how CDC's budget will be tied to these new priorities.

Despite a recognized effort by the agency to synchronize the objectives, the Task Force repeatedly heard frustration with the seemingly "unequal footing" among the objectives. Many of the objectives combine several risk factors and diseases, so when they are selected as high priority it is difficult to ascertain what is actually being given priority. The objectives that are made up of broad statements should be narrowed to be operational. Also, all of the objectives should use language that allows potential measurability. In general, the Preparedness objectives are more binary, and therefore more difficult to measure, than objectives in other goal areas. Continued work is required to harmonize the objectives.

A fair amount of overlap remains between the Healthy People and the Healthy Places objectives. The Task Force observes that the line between the two can be fuzzy at times, but it maintains that CDC must ensure that the distinction is clear so the categories do not appear to be artificial constraints and to guard against creating new silos to replace older ones.

It is important to note, however, that this separation goes against some traditional cultural beliefs. For example, at the tribal leaders' meeting it was explained that Native American culture teaches that the individual and the land are inextricably linked and at times one and the same. CDC should consider such cultural sensitivities when forming categories to present externally.

4.8 PARTNERSHIPS

The Task Force believes that the partner and public engagement process is strong evidence of CDC's commitment to working closely with its external constituencies. Many people at the partner and public events expressed appreciation at the opportunity to participate in the process. They will be eager to see how their participation has affected the development and prioritizing of the objectives.

Expectations are high. CDC's challenge will be to institutionalize its processes for engaging partners. Strong relationships with government agencies and private organizations are not only critical as CDC develops its objectives but will of course be essential as CDC works to achieve the objectives.

CDC collaborates with many organizations whose missions are closely aligned with its own. CDC's authority and expertise in these collaborations are clear. Partners encouraged CDC to stimulate the involvement of groups that have not been heavily involved in health issues but that could play a critical role in achieving the objectives.

In addition, many participants at the partner and public events noted that it was essential for CDC to leverage partnerships in areas that are within CDC's sphere of influence but in which CDC is not the lead agency. In particular, participants identified mental health, substance abuse, access to healthcare, and poverty as areas in which CDC can leverage partnerships. For example, CDC can act as a convener, coordinator, and valued participant, not just as an agency that operates important programs.

A number of people noted that while it is very important for CDC to coordinate with its sister agencies in the Public Health Service as it develops its objectives, it did not appear that these other agencies were invited to participate in the process. Questions were raised specifically about whether the Health Resources and Services Administration, National Institutes of Health, and the Substance Abuse and Mental Health Services Administration were involved in CDC's objective-setting process.

In addition, many people were unclear about the relationship between CDC's objectives and the Healthy People 2010 and 2020 objectives. This suggests that CDC needs to do a better job of communicating the distinctions between these initiatives.

Maintaining constructive partnerships is a long-term proposition. Partners identified several actions that they felt strongly that CDC should take. First, many partners want very much for CDC to give them the opportunity to provide input into the Goal Action Plans. Since the Goal Action Plans will be far more specific than the objectives, this is where partners felt they could offer the most meaningful input. Second, while partners understood that applying the criteria to the objectives will be challenging, they felt strongly that CDC should make public exactly how the criteria are applied and how this then affects CDC's priority setting. Clearly, partners would value the opportunity to review and comment on this process.

By actively reaching out to partners and to the public to help shape CDC's priorities, CDC has created an expectation that meaningful engagements will continue into the future. CDC must now fulfill this expectation.

4.9 PARTNER AND PUBLIC ENGAGEMENT

4.9.1 The Current Partner and Public Engagement Process

The Task Force agrees with CDC that for multiple reasons it is wise to engage partners of all sorts in the ongoing processes of developing and assessing priorities. This particular process of partner and public engagement had some widely perceived bumps along the way, and the Task Force recognizes that CDC is debriefing key people to understand how to avoid repeating those missteps. While this report is not a primer on partner and public engagement, much friendly advice has been provided throughout the engagements on ways this set of engagement sessions could be improved.

- While soliciting feedback on an unfinished product to let the input help guide the formation of the final version is commendable, putting forth a poorly developed document is unwise. Much discussion time was lost to items of an "editorial" nature, such as overlap between objectives in different goal areas, inconsistent wording among similar objectives, and lack of parallel structure among objectives. This continually confounded the priority-setting process. The Task Force found itself still addressing these issues in this report and believes opportunities were lost to probe deeply into substantive matters.
- Prepare answers to important questions before the first meeting. What does it mean to be a partner? How will these priorities influence budget decisions? How are these objectives related to Healthy People? How will the criteria be used to set priorities? How will health disparities be addressed? Questions like these deserve clear, thoughtful answers from CDC at the outset of the engagement process.
- Determine specifically from whom CDC wants to hear and about what. Be sure recruitment strategies will yield the desired audience. Be sure that the meeting content and questions are of interest to and appropriate for each audience. There are different reasons for seeking input from partners in national and international organizations, from key players in the public health system, and from the general public; and the engagement process will be most successful when tailored to each.
- Establish clear lines of authority and communication for project management. Designate one official with final authority on a large, national information collection project such as this one.
- Allow time to develop clear work plans with all parties responsible for carrying out project activities, including building in sufficient time for planning, reviewing, and reporting. Plan which documents will be needed and for whom; be sure each document or report has a clear purpose and audience and dissemination plan. When planning and organizing events with the general public, allow sufficient time to garner active participation of local officials, agencies, and organizations in the planning and allow sufficient time and resources to recruit appropriate participants.
- Allow time to have a true dialogue with any partners who may play a role in the process. True partnership takes time to develop shared understandings.
- Develop data and information collection to achieve the specific purposes of the project. When doing qualitative work, use the widely recognized qualitative research data collection methods common to public health practice. Pretest materials and procedures and allow time to incorporate changes.
- Plan for dissemination of findings at the outset.

4.9.2 Moving Ahead on Partner and Public Engagement

It is *not* recommended that CDC hold additional engagements regarding the existing set of criteria and objectives. The issues cited above and the consistency of the feedback received during the engagements lead the Task Force to conclude that little additional information will be gleaned from such engagements.

That said, this engagement process did raise expectations from many quarters that CDC will take this input seriously and have a process in place for reporting back to partners and to state and

local health departments the actions taken on the criteria and objectives as well as establishing and nurturing partnerships. The Task Force plans to remain engaged in this process with CDC as Goal Action Plans are developed and implemented.

If, in the future, additional feedback from a wider range of public health professionals on a revised set of objectives is desired, it is suggested that CDC look first to public health partners to participate in soliciting that feedback. Similarly, other partners could help obtain feedback from groups that were missed in this first foray.

If CDC wishes to reach out to the general public, the Task Force urges use of sound qualitative methods that systematically solicit views of the public on health issues of importance. Ranking a large set of objectives that require extensive explanation about CDC's role would not be likely to yield an "engaging" experience.

The Task Force's best advice is that CDC continue to work consistently to develop a culture where engaging partners and, when appropriate, the public will be a routine part of priority setting, program development and implementation, and assessment of the many facets of CDC's responsibilities.

APPENDIX A

HEALTH PROTECTION GOALS WITH OBJECTIVES

Overarching Goal #1:
Healthy People at Every Stage of Life

All people, and especially those at greater risk of health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life.

Strategic Goal: Start Strong
Increase the number of infants and toddlers that have a strong start for healthy and safe lives. (Infants and toddlers, ages 0–3 years)

Objective 1: Reduce infectious diseases and other preventable conditions and their consequences among infants and toddlers.

Objective 2: Prevent injury and violence and their consequences among infants and toddlers.

Objective 3: Promote healthy pregnancy and birth outcomes.

Objective 4: Promote optimal development among infants and toddlers.

Objective 5: Increase early identification, tracking, and follow up of infants and toddlers with special healthcare and developmental needs.

Objective 6: Increase the numbers of infants and toddlers who live in social and physical environments that support their health, safety, and development.

Objective 7: Increase the numbers of infants and toddlers who have access to and receive quality, comprehensive, pediatric health services, including dental services.

Objective 8: Improve risk and protective factors for future disease among infants and toddlers.

Strategic Goal: Grow Safe and Strong Increase the number of children who grow up healthy, safe, and ready to learn. (Children, ages 4–11 years)

Objective 9: Prevent chronic diseases and their consequences among children.

Objective 10: Prevent infectious diseases and their consequences among children.

Objective 11: Prevent injury and violence and their consequences among children.

Objective 12: Increase early identification, tracking, and follow up of children with special healthcare and developmental needs.

Objective 13: Increase the numbers of children who live, learn, and play in social and physical environments that are accessible, that support health, safety, and development, and that promote healthy behaviors.

Objective 14: Increase the numbers of children who receive quality, comprehensive, pediatric healthcare, including mental health and dental care.

Objective 15: Improve risk and protective factors for future disease among children.

Strategic Goal: Achieve Healthy Independence Increase the number of adolescents who are prepared to be healthy, safe, independent, and productive members of society. (Adolescents, ages 12–19 years)

Objective 16: Increase the numbers of adolescents who live, learn, work, and play in social and physical environments that are accessible, that support health, safety, and development, and that promote healthy behaviors.

Objective 17: Increase the numbers of adolescents who receive recommended effective, evidence-based preventive and healthcare services.

Objective 18: Prevent injury, violence, and suicide and their consequences among adolescents.

Objective 19: Prevent HIV, sexually transmitted diseases (STDs), and unintended pregnancies and their consequences among adolescents.

Objective 20: Promote healthy activity and nutrition behaviors and prevent overweight and its consequences among adolescents.

Objective 21: Prevent substance use, including tobacco, alcohol, and other drugs, among adolescents.

Strategic Goal: Live a Healthy, Productive, and Satisfying Life Increase the number of adults who are healthy and able to participate fully in life activities and enter their later years with optimum health. (Adults, ages 20–49 years)

Objective 22: Prevent chronic diseases and their consequences among adults.

Objective 23: Prevent infectious diseases and their consequences among adults.

Objective 24: Prevent injury, violence, suicide, and their consequences among adults.

Objective 25: Promote reproductive and sexual health among adults.

Objective 26: Increase the numbers of adults who live, work, and play in social and physical environments that are accessible, that support their health, safety, and quality of life, and that promote healthy behaviors.

Objective 27: Increase the numbers of adults who receive recommended preventative and physical, mental, and dental healthcare services.

Objective 28: Improve risk and protective factors for future disease among adults.

Strategic Goal: Live Better, Longer Increase the number of older adults and the elderly who live longer, high-quality, productive, and independent lives. (Older adults and the elderly, ages 50 and over)

Objective 29: Prevent chronic diseases and their consequences among older adults and the elderly.

Objective 30: Prevent infectious diseases and their consequences among older adults and the elderly.

Objective 31: Prevent injury, violence, and suicide and their consequences among older adults and the elderly.

Objective 32: Promote independence and optimal physical, mental, and social functioning of older adults and the elderly.

Objective 33: Increase the numbers of older adults and the elderly who live, work, and play in social and physical environments that are accessible, that support their health, safety and quality of life, and that promote healthy behaviors.

Objective 34: Increase the numbers of older adults and the elderly who receive recommended preventive and physical, mental, and dental healthcare services.

Objective 35: Improve risk and protective factors for future disease among older adults and the elderly.

Overarching Goal #2:
Healthy People in Healthy Places

The places where people live, work, learn, and play will protect and promote their health and safety, especially those at greater risk of health disparities.

Strategic Goal: Healthy Communities Increase the number of communities that protect and promote health and safety and prevent illness and injury.

Objective 36: Increase the number of communities that have high-quality air, water, food, and waste disposal, and are safe from toxic, infectious, and other hazards.

Objective 37: Increase the number of communities that have robust, sustainable capacity to prevent, detect, and control infectious diseases.

Objective 38: Support the design and development of built environments that promote physical and mental health by encouraging healthy behaviors, quality of life, and social connectedness.

Objective 39: Support equitable access to and receipt of essential health promotion, health education, public health, and medical services.

Objective 40: Understand and reduce the negative health consequences of climate change.

Objective 41: Prevent injuries and violence and their consequences in communities.

Objective 42: Improve the social determinants of health such as poverty, discrimination, and poor education among communities with excess burden and risk.

Strategic Goal: Healthy Homes
Protect and promote health through safe and healthy home environments.

Objective 43: Increase the numbers of homes that are free from health and safety hazards.

Objective 44: Increase the numbers of people who have adequate knowledge and adopt behaviors to keep their homes safe and healthy.

Objective 45: Increase the availability of healthy, safe, and accessible homes.

Strategic Goal: Healthy Travel and Recreation

Objective 46: Promote injury-free travel and recreation.

Objective 47: Prevent illness during travel and recreation.

Objective 48: Promote safe, accessible, and healthy environments for travel and recreation.

Strategic Goal: Healthy Healthcare Settings Increase the number of healthcare settings that provide safe, effective, and satisfying patient care.

Objective 49: Increase the delivery of good quality prevention and screening services in healthcare settings.

Objective 50: Increase the number of healthcare settings that comply with evidence-based guidelines for disease identification and management.

Objective 51: Increase the numbers of healthcare settings that protect patients and healthcare workers against adverse events.

Objective 52: Increase the number of healthcare environments that promote health, safety, and accessibility.

Objective 53: Increase the numbers of healthcare settings that provide patient-centered clinical care and prevention services.

Strategic Goal: Healthy Institutions Increase the number of institutions that provide safe, healthy, and equitable environments for their residents, clients, or inmates.

Objective 54: Prevent infectious diseases and their consequences among people in institutional settings.

Objective 55: Prevent chronic diseases and their consequences among people in institutional settings.

Objective 56: Prevent injuries and violence and their consequences among people in institutional settings.

Objective 57: Increase health promotion programs in institutions.

Objective 58: Increase the numbers of institutional settings that are designed, constructed, and modified to be hazard free and promote health.

Objective 59: Increase continuity of care through integration of institutional public health and medical systems with community health systems.

Strategic Goal: Healthy Schools Increase the number of schools that protect and promote health, safety, and development of all students, and protect and promote health and safety of all staff.

Objective 60: Increase the number of schools that promote the health and safety of students, their families, and school staff by implementing a comprehensive program of instruction, programs, policies, and services.

Objective 61: Increase the number of schools that promote students' development and academic achievement.

Objective 62: Increase the number of schools that have safe, healthy, and accessible social, psychological, emotional, and physical environment.

Strategic Goal: Healthy Workplaces Promote and protect the health and safety of people who work by preventing workplace-related fatalities, illnesses, injuries, and personal health risks.

Objective 63: Reduce the number of workers that are killed, injured, or made ill on the job.

Objective 64: Increase the number of workplaces that coordinate worker safety and health efforts with efforts to promote the health and well-being of workers, their families, and their communities.

Overarching Goal #3:
People Prepared for Emerging Health Threats
CDC's preparedness activities-spanning the spectrum from mental health to environmental health-will help in safeguarding lives and responding to threats.

Objective 65: All Hazards - People in all communities will be protected from any emerging health threat using an all-hazards approach to preparedness.

Objective 66: Pandemic Flu - People in all communities will be protected from pandemic influenza.

Objective 67: Natural Disasters - People in all communities will be protected from natural disasters like hurricanes and earthquakes.

Objective 68: Emerging Infectious Disease - People in all communities will be protected from emerging and new infectious diseases like SARS, West Nile virus, and E. coli 157.

Objective 69: Bioterrorism or Other Terrorism - People in all communities will be protected from bioterrorism and other terrorism like the attacks on U.S. on September 11, 2001 and the anthrax attacks.

Objective 70: Occupational Disasters - People, including workers, in all communities will be protected from occupational disasters like chemical explosions and radiation exposures.

Overarching Goal #4:
Healthy People in a Healthy World:

People around the world will live safer, healthier, and longer lives through health promotion, health protection, and health diplomacy.

Strategic Goal: Global Health Promotion Global health will improve by sharing knowledge, tools, and other resources with people and partners around the world.

Objective 71: Prevent infectious diseases and their consequences.

Objective 72: Reduce child mortality by addressing issues such as: acute respiratory infections, diarrheal disease, improved nutrition, safe and sustainable sources of drinking water worldwide.

Objective 73: Prevent non-communicable diseases and conditions and their consequences.

Objective 74: Prevent injuries and their consequences.

Objective 75: Promote safe, healthy, and accessible physical environments.

Objective 76: Improve response to global natural disasters.

Strategic Goal: Global Health Diplomacy CDC and the United States Government will be a trusted and effective resource for health development and health protection around the globe.

Objective 77: Increase access to quality healthcare.

Objective 78: Support achievement of Assembly, World Health Organization (WHO) global and regional goals for disease eradication or elimination.

Objective 79: Develop sustainable public health capacity.

Objective 80: Reduce maternal mortality.

Objective 81: Promote health among refugee populations.

Strategic Goal: Global Health Protection Americans at home and abroad will be protected from health threats through a transnational prevention, detection, and response network.

Objective 82: Increase global capacity to detect, verify, respond to, contain, and prevent emergent health threats.