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Record of the Proceedings

Centers for Disease Control and Prevention
Advisory Committee to the Director
Health Disparities Subcommittee

Meeting Held September 20-21, 2006

SEPTEMBER 20, 2006

On September 20, 2006, Dr. Walter Williams, CDC's Associate Director of Minority Health, welcomed several members of CDC's Subcommittee on Minority Health for a half-day meeting. The full Subcommittee met on the following day. The purpose of the meeting was to review the criteria and objectives for CDC's health protection work. Under review for the first time in over ten years, these criteria and objectives will be incorporated into action plans. The Subcommittee will then review the draft action plans to ensure that health disparities are well addressed. Those in attendance are listed on Attachment #1.

Meeting overview. Dr. Williams described CDC's development of these objectives and goals with input from all relevant stakeholders. The Subcommittee's input will be reported to its parent committee, the Advisory Committee to the Director (ACD), for consideration in its official recommendations to CDC. This day's meeting was to provide an overview of the objectives, to examine the factors driving CDC's performance and strategic budget allocation, and to communicate CDC's role to external and internal audiences.

Dr. Williams outlined the framework through which CDC conducts its work. It provides scientific expertise, information and tools to help people and communities protect their health, through health promotion, prevention of disease/injury/disability, and preparedness for new threats. He reviewed CDC's core values (integrity, accountability, and respect) and capabilities (excellence in science, workforce and service), as well as its strategic imperatives. The latter, developed in CDC's Futures Initiative, guide its strategy to achieve the maximum health protection impact and to advance health protection research, using a customer focus, disseminating its knowledge around the world, and ensuring the accountability of its management. The new CDC organizational structure was shared.

CDC's core values and capabilities are aligned to achieve four goals: 1) healthy people in every stage of life, 2) healthy people in healthy places, 3) global health and 4) preparedness. The population's health and CDC's goals/objectives are driven by the forces of the social/political environment, globalization, health disparities, changes in the environment, infectious disease and man-made threats, and advances in biotechnology and information technology.

Programs specific to each goal were outlined with the overarching objectives for each.

- Goal 1, focuses on the health of the people across the life stages. The latter were charted to show the progression of primary, secondary and tertiary

prevention, and the systems which may have greatest impact: parents (early), providers (early and late), schools (to early 20s), and the community (adult).

- Goal 2, Healthy Places, addresses settings: communities, homes, schools, workplaces, healthcare settings, institutions, and travel/recreation. Place has a potential impact throughout all life stages. Dimensions of place pertain to specific health improvement actions. Goals for each segment of healthy places were outlined, supporting the concept of unique, "place-specific" health issues and the health impact of physical space and environmental exposures on human health.
- Goal 3, Global Health, moves CDC's work out globally by sharing CDC's health promotion knowledge (core public health program delivery for, e.g., safe water, sanitation, nutrition, infant mortality, reproductive health), health protection of Americans at home and abroad (infrastructure and tools), and health diplomacy (engagement in foreign work through successful host country relations). A shared framework showed each three overlapping. Representative programs for each were outlined.
- Goal 4, Preparedness, is pursued through CDC's all-hazards approach, which was illustrated in a functional public health model for emergency preparedness. Coordinated with national plans, this addresses chronic disease, health risk behaviors, outbreaks and infectious disease, and urgent threats such as terrorism and non-terrorism (e.g., pandemic) threats. CDC's all-hazards approach provides crosscutting support (grants, leadership development, legal capacities/authorities) for surveillance, epidemiological and non-bench research, lab and bench research, and response recovery.

Preparedness overview. The preparedness objectives state an overarching goal and then outline the goals for three time-phased periods (Pre-Event, prevention; Event, detection/report, investigation/control; and Post-Event, recovery, improvement). Five functional all-hazards objectives are listed, with 24 functional scenario-specific objectives and nine performance measures. All could be voted on by the Subcommittee in a block, or compared and prioritized.

Goal action plans will be developed as brief documents suitable for dissemination to a wide variety of audiences. They will consist of a one-page introduction to the strategic goal, and subsequent pages for each objective with its key strategies, actions and measures (with targets). The planning horizon includes fiscal years 2007, 2008, and 2009. The plans are designed to help CDC accelerate health impact by:

- Getting stakeholder, partner and public participation in prioritization.
- Establishing "health value" based on health outcomes and costs, so as to measure, be accountable and compete for funding (i.e., health gain per $1 invested).
- Ensuring the system-wide transparency of health impact results.
- Determining what works through research and being more rigorous about activity-based costing.
- Increasing CDC's focus on "demand" (for health impact) and avoiding the zero-sum competition associated with a "supply" focus (i.e., infrastructure).

Next steps in this process include the Subcommittee's report to the ADC and a presentation at the APHA meeting November 6. Public meetings will be held in October in Oakland, CA; San Antonio, TX; Boston, MA; and Little Rock, AR. A report to the Goal Action Plan teams from the Partners' Task Force[1] is expected in November, addressing its September meeting discussions and the input from the October public meetings. Another meeting to gather input from tribal leaders at the National Indian Health Board Conference also is scheduled for October 13.

Discussion included the following comments:

- Adequate resources will be essential to support the accomplishment of these goals and objectives.
- Since these are cross-agency and cross-disciplinary, the support of Cabinet-level resources and political will are important to success. The report on the recent D.C. meeting, to present CDC's research guide to 11 different departments, was requested. **(ACTION)**
- To develop interventions and address the issues on the ground, in place, requires a unique cooperation not now naturally occurring, particularly to address the interwoven relationships of education and poverty. The DHHS Assistant Secretary of Health, Dr. John Agwunobi, plans to convene relevant organizations, private companies, etc., to discuss the key barriers to a comprehensive approach to health with all agencies beyond HHS.
- Other health disparities that have been eliminated were discussed: measles, syphilis, disparate birth defect incidence among Hispanics, and screening. Setting the goal and establishing a benchmark is a powerful strategy, particularly for disparities related to the social determinants of health (versus those biologically-related).

NCHS Presentation

Mr. Richard J. Klein, of the National Center for Health Statistics (NCHS), presented a midcourse assessment of progress toward the Healthy People 2010 goals to: 1) improve the quality and years of healthy life (888 objectives/sub-objectives); and 2) eliminate disparities among subgroups of the population (a subset of 498 population-based objectives/sub-objectives). An interagency departmental group developed methods over 18 months to measure disparity in a consistent and comparable manner.

Currently, 75% (375) of the population-based objectives of Goal #1 can be tracked. As of 2005, ~11% are accomplished or have been exceeded and 57% are making progress toward the target. Except for native Hawaiians and Pacific Islanders, all population groups are progressing toward improving the length and quality of life. The Interagency Working Group agreed to measure Goal #2 in relative rates (percent difference) rather than absolute rates, with the best group rate chosen as the comparison group.

[1] The Partners Task Force on Objectives consists of individual leaders from multiple sectors, convened by the Partnership for Prevention and CDC.

Mid -course review data. The number of objectives with data for each racial/ethnic sub-group varies (e.g., there are relatively fewer data for American Indians). Charted data indicated Native Hawaiians as having achieved the most progress, as compared to Hispanics. Disparities among racial and ethnic groups are present, although some do better than others. The data showed:

- Analyzed by gender, women did better than men, showing smaller disparities.
- Groups with the most education or income were closer to achieving the goals.
- Geographic location: It was interesting that the urban MSMAs have a larger percentage of measures showing them as the best (comparison) group; but outside of MSMAs, a greater percentage had large disparities.
- Disability status showed little difference in disparities, perhaps because persons with disability may have more contact with the medical system and, therefore, have access to care advantages.

To indicate disparities at a point in time, the mid-point review took the latest data and compared it to baseline (~1998). The result was expressed in percentage points, subtracting percent differences from the best group versus the group of interest, for the most recent data point.

In terms of progress toward Goals 1 and 2, the disparities are persisting. There are a few changes, but decreases and increases of ≥10% are about the same. Although most objectives are moving toward the target, most showed no statistical change in disparity over the tracking period.

The best case shared was of new cases of hepatitis A. Data showed a gradual and successful downtrend for all groups from1997-2003. But for many categories, while the death rates are declining, (e.g., from coronary heart disease), the disparities remain close to baseline. And in some cases (e.g., rates for congenital syphilis), disparities are actually increasing.

Several methods of considering disparities when prioritizing public health attention were discussed:

- *Changes in disparities.* While the rates for several Healthy People 2010 objectives reflected decreasing racial and ethnic disparity overall, those for specific minority groups have not declined. For example, declining racial/ethnic disparities for new AIDS cases do not apply to black non-Hispanics, whose rate is 1400% higher than that for Asians; and Hispanics have twice the hepatitis A rate versus the best group rate. The conclusion was that progress in health status and elimination of disparities are goals independent of each other; one could improve as another gets worse.
- *Health disparities shared by ≥3 racial/ethnic groups*. Objectives related to TB, drug-induced deaths, congenital syphilis, cirrhosis deaths and deaths from poisoning all apply to this option.
- *The size of the relative disparity.* In some cases, absolute disparities may be more appropriate than relative comparisons.

- *Burden due to the number of groups or individuals affected*. The number of excess deaths is the observed number of deaths minus the expected number of deaths, if each of the other groups had the same rate as the best group (i.e., that with no excess deaths). If that were the case for unintentional injury, charted data showed that the largest number of deaths would have been averted for white non-Hispanics and 422 additional deaths would be averted among all of the other race-ethnic groups. But for deaths due to homicide, white non-Hispanics had the best rate, and 151 deaths would have been averted among the other racial and ethnic groups.

The questions. So, the relevant questions include: a) whether prioritization should go to the greatest benefit for greatest number, or to benefit a larger proportion percentage? That is, should the Healthy People 2010 driver be the definition (i.e. racial/ethnic groups, weighted by population size), or should all groups be able to achieve the rate of the best group, regardless of their size (i.e., all groups are given the same weight, statistically speaking)? Healthy People 2010 also defines "elimination" as the absence of disparity between any two subgroups being compared. Given the unclear feasibility of accomplishing this by 2010, other questions are: b) how to accomplish that; and c) how close is close enough (a policy question)?

Discussion noted that, in comparing two points in time, it is possible that the "best" group can change between points of comparison, making the concept of "best rate" harder to understand. Data points raised included:

- Over 200 data sources were used in this midpoint analysis, mostly from the NHIS, but also from Vital Statistics, NHANES, BRFSS and others. The best rates are based on those of populations in the contiguous U.S. states and D.C.
- Foreign best rates, when they exceed those of the U.S., could be used as a benchmark
- The ability to conduct in-person surveys in non-English languages is relevant to their results.
- The inability of current data collection to address Healthy People 2010's 29 objectives based on sexual orientation is a weakness.
- Data were requested on any comparison of persons with disability to other groups. **(ACTION)**

Dr. Ben Truman reported that the DHHS Office of Disease Prevention/Health Promotion in D.C. developed those data sets. As they are completed, they will be released.

Subsequently, Dr. Williams outlined the Subcommittee's charge to develop specific disparity objectives and the criteria with which to assess them, part of which involves prioritization. Frank opinions were requested on CDC's approach to disparities, what else it could do, and whether CDC's approach addressing high-priority public health areas involving disparities would be adequate. With that, the meeting ended, to reconvene on the following morning at 8:40 a.m..

SEPTEMBER 21, 2006

Mr. Michael Hughes, of the Keystone Center, served as the meeting facilitator on this day. The Keystone Center assisted the CDC and the Partnership for Prevention in developing the Starter Objectives working document used in this meeting. These eighty objectives had been winnowed down from a much more extensive list of hundreds. The Subcommittee was asked to help identify the most pressing priorities for CDC and a set of criteria to use in prioritization. This also had been done at the Partners Meeting on September 19-20 in D.C. and, in October, would to be done with the public around the country.

Overview of CDC Goals.
Dr. Brad Perkins, Director of the Office of Strategy and Innovation, outlined the context of this process. He expressed the opinion that public health is facing big opportunities – and challenges – so large that continuing to do work as done in the past is unlikely to succeed.

Background. The National Governors' Association meeting in February issued a call to action in its "Healthy America" report. This underscored the U.S.' looming health and economic concerns due to poor nutrition and lack of physical activity. Ninety million Americans have chronic disease and 300 million pay for its effects. By 2015, 20% of the gross domestic product will be devoted to health care, with little value for that level of investment. Obesity data charted from the work of David Katz, Director of Harvard's Prevention Research Center, showed the rising likelihood that future college students will present in emergency rooms with cardiac infarctions and Type II diabetes. So far, public health has not seriously attacked this problem.

However, there are some hopeful signs:

- *The Everyday Choices Program.* The American Cancer Society, American Diabetes Association, and American Heart Association joined to target the 90 million Americans with chronic disease, and the rest of the population with prevention messages.
- *The Partnership for Prevention* prioritized preventive services (National Commission on Prevention Priorities, June 19, 2006). An analysis of 702 population-based interventions for the leading health conditions showed that only ~4% have solid effectiveness data to support them. And, of 55% of adults receiving recommended preventive interventions, only 18% received appropriate counseling or education. The Partnership scored and ranked 25 leading interventions for effectiveness, and their Website has data for each of the clinical preventive services. For example, if the use of daily aspirin could be promoted to the 80% of the population that does not take it, ~80,000 lives per year could be saved from averted myocardial infarction.
- *State summits on pandemic influenza planning* have been held nationally. While these raised and improved recognition of the value of public health, Dr. Perkins was unsure they were maximally used for public health impact.

The challenges. Chris Murray's data, released the week previous to this meeting (Murray et al, PloS Medicine 2006;3[9]:e260), confirm that the U.S. has not come close to resolving the problem of health disparities. Murray termed the mortality disparities "enormous by all international standards." He recommended 1) epidemiologic and economic studies to identify ten affordable health interventions (for populations or individuals) that, if applied, would make the biggest difference to those with the worst health; 2) state/territorial monitoring systems to provide local, benchmarked data on the fraction of each community's population that would benefit from the ten interventions; and 3) public reports on the interventions' delivery to different communities. In his 2005 paper, Murray outlined steps to address mortality disparities. He called for a broad-based national approach to disparity, at least at a life expectancy level. One provocative assertion was that health disparities and life expectancy could be most effectively addressed with a focus on older children and adults, rather than younger children and older adults

The Trust for America's Health (TFAH) also issued relevant reports in 2005 and 2006:

- "F as in Fat," 2006, found no national strategy policy to address obesity, despite its serious impact on the nation's health and economy. It urged systematic study of the connection between spending and health and research for a better understanding of Americans' health, to allow for targeted, smarter investments where they are most needed.
- "Shortchanging America's Health," 2006, called for increased and sustained national support for essential disease and injury prevention services as a higher priority.
- "Ready or Not?," 2005, acknowledged "significant progress" since 9/11 in federal efforts related to public health and bioterrorism performance, but rated performance in those two areas as still only a "D+." CDC was also criticized for an inability to show results demonstrating America's better preparation in preparedness, pandemic influenza, and putting needed funding out to the states.

Kaiser Foundation data indicate that 39 million people worldwide are infected with HIV/AIDS. There are 14 million with TB, and 14 million with malaria, the latter killing 2000 children a day. But again, there are positive steps underway.

- In the private sector, two of the world's richest men, Bill Gates and Warren Buffett, have stepped up, pledging a total of $68 billion to fight TB, malaria and HIV/AIDS.
- The President's Emergency Plans For AIDS Relief (PEPFAR) is very outcomes-focused and is directed to the 15 countries housing ~50% of the world's 39 million people infected with HIV/AIDS. By 2008, PEPFAR aims to prevent 7 million new infections, to treat 2 million people with HIV/AIDS, and to provide care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children.

The framework of CDC's four goals (healthy people, places, preparedness, world) were outlined again to illustrate their focus. Healthy people involves a life stages approach that

integrates the previous risk-based approach; healthy places integrates environmental work to focus on the places where people spend most of their time; the measurement metrics for preparedness are based on rapid and high-quality emergency responses; and healthy people in a healthy world focuses on global health through health promotion, protection, and diplomacy.

Goal action plans. The strategic change occurring is that, rather than working on each goal separately, CDC is working through scenarios that crosscut them, using the vehicle of Goal Action Plans. These will be versatile, for release to multiple audiences, and will be refreshed annually. The plans will have a one-page introduction to state the strategic goal; another with key strategies, actions, and measures (with targets); and others to show planning in a 3-year time horizon (FY2007-2009).

A figure adapted from Porter and Tiesberg ("Redefining Health Care," 2006) was shown to illustrate how rising relative quality (as the value of interventions are shown and their use increases) leads to decreasing relative cost, and spurs competitiveness and innovation to produce a greater health impact.

Discussion included clarification that part of the measurement includes health disparities based on healthcare access, to make the value at all levels transparent. But Murray's data indicate that disparities may not be based on healthcare access, at least relative to life expectancy. CDC's budget was aligned to these goal areas, in order to assess the investment for each life stage – which showed it to be "quite out of balance." The largest investment in adult health at CDC to date, by a factor of ten, is HIV/AIDS. This exercise revealed gaps in addressing health burden. While there have not been dramatic decreases to CDC budget, there was a $267 million decrease overall, spread over the agency. But part of that, for example, was the budget elimination of the VERB program, which was the best campaign ever to provide health impact across racial and ethnic groups. Dr. Perkins termed that "totally unacceptable." Whether government- or privately-funded, that program must be kept going to maintain CDC's credibility. Dr. Yancey added that an IOM committee called for refunding that project. Many programs run on much fewer data than VERB's.

The Public Engagement Process was presented by Dr. Christine Branche, Director of the Division of Unintentional Injury Prevention, which resides in CDC's National Center for Injury Prevention and Control. This meeting was the second of the two planned Partner meetings to share the criteria developed within CDC. She noted the uncharacteristic nature of CDC's release of anything not yet refined to near-perfection. This reflects the agency's desire for real-world information, with which to alter the objectives and criteria as needed. The five public meetings to begin October will supplement that feedback.

Dr. Branche outlined CDC's considerations, which included its core values (integrity, accountability, respect) and its core capabilities (excellence in science, workforce, service). Specifically, it considered:

- The strength/development stage of the science.
- Respect for the culture/value of the places where CDC works.

- Consideration of both the domestic and international sides to CDC's work as full parts of CDC work.
- The need for CDC to be fiscally responsibility in its work.

In applying the criteria, she asked the Subcommittee to consider whether additional criteria are needed, how the criteria should be weighted, and if any criteria are added, how they should be weighted?

Later, this meeting's contributions will be incorporated to all others. The members' completed evaluation form or ad lib comments were welcomed, including after the meeting.

Four criteria for the objectives were outlined:

- Why is the health issue important?
- How are different groups/communities affected, relative to burden (urgent realities), morbidity/mortality, prevalence, QALYs, etc. A list was developed with DHHS headquarters to define disparity in populations by: racial identity/ethnicity; SES, age, gender, geography, disability status, risk regarding sex and gender, and other populations identified as at risk for health disparities (e.g., those incarcerated).
- Is it feasible to make progress on the objective today, or does it present a research opportunity?
- Is the objective consistent with CDC's mission, core values, and interests?

Mr. Hughes summarized that the criteria were developed to allow the incorporation of facts, science and technologic information to bear on the decision-making, as well as to apply values. He asked first for discussion of *whether the criteria are clear, and if not, how could they be clarified?*

Discussion included the following points:

- Many of the burdens that people of color live with are not on this list, such as the stress of living with poverty and in a major underground culture within the overall society. Changes in the lifestyle of the minority community also are needed to improve the quality of life.
- Gaps in capturing social determinants need to be filled. Partners may have relevant information to bear that is not captured in CDC data -- including economic burden and quality of life.
- Some differences are not related to disparities; disparity should relate to something achievable to that population. Do the differences in age (e.g., those specific to adults not vulnerable to infant health threats) yield some difference in health?
- Use the term "functional limitations" to avoid the inference that living with disability is a negative. Some persons with disabilities have a high quality of life. The same comment was voiced to CDC about the term "burden."

- There seems to be an assumption that the data are both adequate and disaggregated to look at various populations, but as Dr. Perkins observed, that is not true.
- Clarify in the text that CDC's two basic responsibilities (to apply the available science on hand and to invest in future research to improve health impact) are not mutually exclusive

How should CDC shift the analytic framework to move to a more holistic, overarching approach to health disparities? Discussion included:

- There seems to be a gold standard to data collection, but the data are not always available. Community-based participatory research can fill that gap, but it also affects the science itself. Until that is fully articulated, the outcomes desired will not be achieved. The issue/the question should drive the science, rather than an SOP paradigm. For example, is there a better way to approach a mother whose infant has died that is less painful than an immediate interview?
- CDC should work with partners to focus on the root causes of disparities and determinants of health, to determine if they are measurable. They should be part of the definition.
- Models to measure elimination of health disparities include smallpox, which involved a holistic approach, as well as seat belts, air bags, etc., to reduce (if not eliminate) traffic related mortalities.
- The definition of health seems to move from the absence of disease. Rather than burden of disease, the approach could be how to help individuals move forward in their personal, professional, etc., aspirations, from a life stage approach. Rather than chasing the negative, chase the positive. In minority communities, the elderly person may be less concerned with their health problems, per se, than wanting to live a healthier lifestyle to attend a granddaughter's graduation.
- Health information technology should be part of health disparity surveillance so that, as the technology evolves, it can collect appropriate data. This also relates to cultural competence, which is not clearly addressed in the material.
- CDC's budgeting process likely will be driven by these goals and objectives. How can it be ensured that resources focus on the populations at highest risk? If, for example, HIV objectives are prioritized for the adult life stage goal, how does CDC look at and fund population-specific issues? Dr. Perkins responded that the Goal Action Plans will address that. Perhaps a more sweeping, cross- cutting approach to disparities is needed, focusing on the clinical preventive services and monitoring their delivery to resolve disparities across the U.S.
- To do such a comprehensive approach, CDC would have to reach out to other agencies; political bridges will be needed as well.
- Not just absence of illness, but Maslowe's hierarchy as applied to CDC's goals, should be considered. To reach the pinnacle of self-expression, basic needs must be met. On the other hand, the opinion was voiced that Maslowe is a good idea, but a little dated. A more contemporary idea of social context is

needed. Murray's work seems based on that idea, and pushes for building the science with a set of interventions/strategies.

- The latter involves a fundamental paradigm shift. Since most systematic disparity research has had a biomedical base and an epidemiological approach, this change would require a redefinition of science. While we still need to build those sciences, we also need to increase the evidence base to include place and context. These are areas of scientific knowledge, but not applied to health. The broader scientific paradigm needs to be more multi-disciplinary, beyond the medical and behavioral sciences, and raise questions of expanding the evidence base to define health and health disparities. More systematic thought about the knowledge of science and interventions is needed to legitimize that.
- The development of CDC's research agenda included many people. Reference that consensus process to reach as many different areas of disparities as possible. Provide that report to the Subcommittee. **(ACTION)**
- One reason the U.S. falls below other nations is that it has no universal healthcare coverage. The U.S. healthcare system is complex and, as middle class people lose their health insurance, many of things that were not variables before will become so now (e.g., increased infant mortality among white middle class women without access to fertility treatments).
- Health status reflects income, education, and insurance coverage. Partnerships with agencies, non-profits, etc., and use of CDC data to drive the needed changes (e.g., related to minority wages, overcrowded school systems) will be important. CDC outreach and use of its data to call attention to such issues will be important. CDC should be sure that the objectives stay focused on the broader determinants of health and, from an international perspective, that includes the impact of war on public health.
- Under burden, add "discrimination" at all levels to section A.
- Add "incidence" and "emergence" to prevalence, as it is a faster indication of trends.
- Use of the word "criteria" indicates the use of milestones, quantifiable and comparable effects. These will become statements of a benchmark.

How to weight these four criteria? Are disparities paramount? Equal to?

- To fix the weight of the problems, the focus must be on the disparities; that's where the burden is. They could be addressed in sequence, factoring in disparity and feasibility (e.g., on a 2x3 table, high disparity/low quantitative burden versus high burden/low disparity [HB/LD]).
- Pragmatically, they seem to be convergent criteria, hard to disaggregate in an actual planning sense in the real world, given CDC's future and charge. This involves some value judgment; distribution/proportion are also factors. Several aspects of this were discussed:
    - For example, HIV/AIDS is HDHB, but in terms of disparity, community church administrators are dealing with cardiovascular disease, high blood pressure, etc., in terms of who is being buried from their congregation.

Issues of HB and disparity can be very different at the local level. It depends on the setting, which provides context, a driver beyond HDHB. There may be a big qualitative context that makes separation/prioritization difficult. For example, women's breast cancer may have HDHB, but CVD has higher numbers. Breast cancer is more of a gender issue and CVD is less so, more pertinent to racial factors.

- Burden equates to morbidity/mortality, prevalence, QALY and economic burden. But even in their absence, a disparity may exist, and CDC needs to determine how they relate. For example, SIDS risk is highest among American Indians and Alaskan Natives, but SIDS excess deaths are higher in whites than in blacks.
- But HB/LD and LB/HD are only two possible combinations. If all five are included, an index of burden, feasibility, relevance, etc., is needed first, with all combinations. Use of such a complicated matrix to apply to all objectives would be very difficult. But pragmatically, all four dimensions could be examined, not so much prioritizing as juxtaposing. HBHD, plus CDC mission and feasibility could be the selection basis, with the understanding that other cells are not as compelling as the mission/feasibility. So, relevance and practicality would be at the top, and the factors can converge.

- Add to the list other dimensions, such as whether anyone other than CDC addresses a health threat, and the political aspect. CDC has to do what is important, but also has to be relevant in areas important to the public (e.g., it must care about lead, but heart disease worries the public most). But many agencies address heart disease; perhaps CDC's role should be more of a coordinator than a programmatic actor.
- Also add to the list "things linked to CDC's broad mission," such as education to increase health literacy. The latter would provide long reach and access to "low hanging fruit," and the ability to capitalize on available resources or areas of current focus. But caution is warranted; if the CDC mission is a hard criterion used to track the budget, OMB budget cutters can use that in refusing funding. A term other than "leverage" is needed to reach around the core mission elements. Other suggestions were: things "potentially affecting population health and under others' domain, but to which CDC could be important player/contributor;" and things "within CDC's authority" or "within CDC's sphere of influence."

What other dimension or elements of health disparities should be considered?

- Political reality dictated the change in section B from "sexual orientation" to "risks related to sexual behavior." The importance was agreed to frame this in a way that is politically salvageable to ensure adequate data collection. Sexual orientation is a very common science and public health term. Restate that to say "risk related to sexuality or gender identity." To address cultural competence in language, add communication issues relative to disparities.
- Other additions to the list suggested were:

    - Add future burden and asthma.
    - Add "country of origin," sometimes not always captured under "ethnicity."
    - Separate cultural competence and culture; "one is what I do, the other is how I live."
    - This focuses on the people, not the system; systemic change allows more rapid adjustment. Perhaps the Goal Action Plan could have a checklist of considerations relative to how the system succeeds or fails to deliver a healthier quality of life.
- Racism is institutional as well as between individuals; articulate that as an integral part of the agenda.
- Another important factor is the feasibility of success on health issues important due to HDHB (some may be level, but never 100%).

Summary: In defining risk and protection factors, broaden risk (i.e., to include stress, sexual orientation, etc.) to more fully consider risk protection. Some of the harder trade-offs require contextualization. Both risk and protection require complex thought at many levels.

- There are many data sets other than DHHS.' Perhaps one role for CDC is to convene them, rather than collecting data, to further illuminate the questions and issues of disparities. Pick that up in the objectives.
- Additionally, it is very important to add another criterion related to CDC's role, rather than its mission. So, add a section E: CDC role and partnership; or take D to a higher level to focus on the CDC mission and then separately on CDC leveraging. Very explicitly make this a separate bullet. Or, put it under "CDC's sphere of influence," but make it more explicit.

What do these criteria mean to CDC's actual work?.

- Each criterion must be rephrased to state "how much." For example, how important is the issue; how feasible is it to make progress, etc. This need not necessarily be numeric; this could be a high/low delineation.
- Social determinants are part of A, but also need to be explicitly stated under Risk or Threat, and the second dash should be split to add protection and assets to set up partnership possibilities from the beginning.

The meeting then was adjourned for lunch, after which the Subcommittee prioritized their top 25 of the 80 objectives.

Prioritization Exercise of Starter Objectives

Dr. Branche outlined how the starter objectives were developed. An original list of 250, developed by CDC's Coordinating Centers and Offices, was reviewed by a CDC workgroup. This group consolidated and de-duplicated them, assured similar levels of scale, removed objectives outside of CDC's scope of work, and edited for clarity. The resulting 80 starter objectives served as the beginning of discussion. These will be refined

with internal and external engagement from September through December, with data and criteria applied that include the potential to improve health.

Dr. Branche provided the definitions of the basic components of this work: goal, health, strategy, action, and measure. An important factor of this process is that the objectives are intended to bridge broader goals to more specific measures, strategies and actions. Those are limited in number (80), and will be broadly communicated to larger groups, including the public. As they cover a broad range of potential CDC public health activities, they are broader and less specific than what is normally understood as an "objective." They are neither time phased nor measurable, as are the Healthy People 2010 objectives. The measures, however, will be more numerous and specific, will be subsets to the objectives, and will be part of the subsequent Goal Action Plans. Each CDC objective will support multiple Healthy People 2010 objectives, with complementary structures.

Attention to health disparities is ensured by their systematic, clear identification and address in every Goal Action Plan, and in the widest sense, not just for populations. This requires dedicated resources, measures and actions. That inclusion in each action plan was immediately supported by Drs. Benjamin and Rios.

Dr. Branche explained that the Preparedness goals were all grouped together in the all-hazards approach under objective #80, to cover all known scenarios (which were listed) plus all unknown future scenarios. Since they are all interrelated, she asked for the Subcommittee's prioritization of #80 as a block.

Dr. Benjamin commented that such a grouping could be done with many other objectives which also mesh well together, such as some related to chronic disease or early childhood. Dr. Branche responded that CDC is open to those suggestions. Finally, she thanked Dr. Williams and the meeting organizers for all their work to accomplish this meeting.

Prioritization vote. Using the list of 80 objectives, the Subcommittee electronically voted on the priority of each. The raw scores are appended to this report (Attachment #2). With the acknowledgement that the "N" for this exercise was small, the top ten objectives and their percentage votes (not in ranked order) were as follow.

1. (Objective #1) Reduce infectious diseases and other preventable conditions and their consequences among infants and toddlers: 63%.
2. (#8) Improve risk and protective factors for future disease among infants and toddlers: 75%.
3. (#13) Increase the number 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: 65%.
4. (#20) Promote healthy activity and nutrition behaviors and prevent overweight and its consequences among adolescents: 63%.
5. (#28) Improve risk and protective factors for future disease among adults: 63%.

6. (#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: 63%.
7. (#39) Support equitable access to and receipt of essential health promotion, health education, public health, and medical services: 75%.
8. (#42) Improve the social determinants of health such as poverty, discrimination, and poor education among communities with excess burden and risk: 100%.
9. (#65) Increase the number of workers who have coverage for and receipt of clinical preventive health services: 63%.
10. (#80) Preparedness objectives are capacity based and will be applied in various combinations to all of the above goals. Specific goal-related performance measures will be applied to all applicable strategies and actions contributing to these objectives: 75%.

Discussion included the following comments:

- This included none of the Partner questions; schools, workplaces and businesses were chosen.
- While people and communities did well on scoring, places did less well.
- Those chosen skew towards primary prevention or underlying factors of diseases (which also imply prevention).
- To assess how well the criteria work for prioritization, review each according to their positivity rather than their score, to see what happens.
- Pay attention to those with zero votes, to review possible major implications if that work is dropped from CDC's portfolio. (Dr. Branche reassured that this would not happen; program focus was the context.) Those being polled should not be given implausible choices. For example, not selecting #5 means that children with disabilities would not be tracked, to ensure they are getting services. That pertains to many other objective categories as well, such as children with special health care/developments needs (#12), prevention of chronic disease among persons in institutions (#58), etc.
- The extent to which the criteria guided the Subcommittee's prioritizations was inquired. While they were used, the members' own relative values were considered as well, such as quality of life. Another comment raised a disconnect for some objectives, which were stated in a way that seemed to elicit the old "boxed," reductive thinking about public health, rather than the forward movement of these criteria.
- It was agreed that better education is needed about the importance of the "newer" areas of public health, such as the fact that injury poses the greatest mortality risk for those aged 14-40 years. To encourage more attention to such data and reduce the "horse trading" of falling back on personal opinion of burden, value judgments, etc., the addition was suggested of a mortality chart early in the presentation to give such context. Perhaps those voting should also be asked to leave their organizational perspective behind in order to attend to the bigger picture.

- Again, CDC should highlight that, while another entity than CDC might address a particular task, its mission could also suggest a collateral contribution to that work.
- *What the groupings indicated.* The top ten categories felt into healthy people (5), places (4), and preparedness (1).
    - Toddlers and infants benefited (25%), but older adults completely lost out (0%); healthy communities benefited in three of seven categories, and healthy workplaces in one of five. While the latter included no specifics such as institutional setting, they may be included under "communities."
    - Similarly, injury and violence were not prioritized. While they could fall under risk factors, the ones selected were more general and inclusive than those that could be isolated. And presumably, the rationale for school prioritization was similar to promotion of health education, health promotion, etc. in a broader sense.
    - Older adults lost out in this round. The traditional primary prevention approach, to which CDC is still attuned, focuses on an earlier stage and secondary/tertiary prevention seems applied to older adults. While primary prevention can still be done for those aged ~50 years, tertiary prevention (which has less funding) might be more valued, and the focus seems to be more on the sequelae of disability (except for tobacco, where data are clear). Older adults also involve questions of access to care and potentially undiagnosed conditions.
    - Research is needed to inform the effects of ageing. Like infants' cycles of maturation change, there also is one for ages 45-120, but there are very little data on those changes.

Is there some burden not included that might have been broached or was not appropriately addressed?

- Objective #24: Prevention of violence, suicide, etc. in young adults (which includes firearm violence).
- #69, preventing child mortality, particularly outside the U.S.
- Prevention of tobacco use.
- A focus on mental health, which also pertains to ageing.
- The way in which many social determinants bear on the human condition: mental health, stress, and range of psychosocial elements. However, this could fall under #36: environmentally safe healthy communities.
- Inclusion in the public health approach of not only risk factors but also protective factors and assets, of which people are one. People need to be challenged to take charge of what they can address. CDC should work with agencies and people in a healthy empowerment mode. Objective #15 has discussed protective factors, but leaves out prevention.

Other comments included:

- The nine other objectives that ranked at 50% could be the next tier of prioritization.

- CDC was asked to report the subsequent ranking of #42 ("Improve the social determinants of health such as poverty, discrimination, and poor education among communities with excess burden and risk") back to the Subcommittee. **(ACTION)**
- Objective *#26 could be the one health objective for the whole 80, if every age group is added.* That could be stated as a goal, listing below what is meant by healthy environment (access to medical care, schools, good water/air, etc.). Flesh out that question to describe what groups live in the most unsafe environments (e.g., violent, unhealthy, etc.).

The Subcommittee's opinion of CDC's approach to disparities was requested. The agency looked at several ways to address health disparities. First, since almost every health status indicator has some disparity, a specific disparity statement could be appended to each objective (e.g., "particularly any groups especially affected"). Second, the data will define where disparities are, and third, the goal teams will examine risk, burden, etc., to identify key disparities for every area and address that in the action plan to ensure tracking and accountability.

- The Subcommittee members' responses again noted the assumption that the data exist, while Healthy People 2010 states that data exist or need to be developed. Dr. Williams explained that the starter objective document acknowledges that data for certain "sub-populations" are inadequate, and that CDC needs to refine its information on health status, quality, etc. This is being done separately from the Goal Action Plan process, but is being systemically addressed in the agency.

Following a short break, Mr. Hughes invited the Subcommittee to attend the October public meetings. He also asked their help in inviting average, "normal" people to attend. These will be held in Oakland, CA, on the 14th; San Antonio, TX, on the 21st; Boston, MA on the 21st; and Little Rock, AR, on the 28th. The Indian Health Board meeting will be in Denver, CO, on the 13th; the APHA presentations will be on the 6th from noon to 2:30 p.m., and the Partners Task Force on Objectives meeting will be on November 15-16.

Final Subcommittee comments on the objectives included:

- The types of things to be prioritized in the rest of the document about the disparity groups (e.g., racial/ethnic) need to be determined, especially since by 2050, ~50% of the population will be in one of those racial/ethnic groups. CDC was urged to consult on this with the Indian Health Board and specific national organizations representing minority communities. With that information in hand, this committee could prioritize again. The URL for minority organizations' input should be distributed, with emphasis that input is desired as a *single* response for the organization. The URL was distributed and is http://www.cdc.gov/osi/goals/workshopPartners.html.
- Next, this Subcommittee should review the Goal Action Plans relative to the input of the organized constituencies.

- With priorities fronting the text of every goal, the Goal Action Plans should be targeted and specific for the Hispanic, African American, etc., communities (listed in B), because the disparities for each group differ. Incorporating more specific items will be critical to making this document more useful.
- A good place to promote this document will be at the APHA meeting, to the Black, Hispanic and Gay/Lesbian Caucuses. Dr. Benjamin offered to announce this workshop in the October APHA newsletter and to send the caucus leaders a specific email about it. Targeting the caucus leaders and promoting this as a unique, important and timely opportunity, was urged.

Next steps suggested were:

- The Subcommittee's formal invitation will explicitly invite the members' organizations to comment on the current Starter Objectives at the URL. CDC will have a succinct protocol for the organizations to follow on the URL. When that is ready, CDC will notify the Subcommittee members by email. **(ACTION)**
- Subsequently, this Subcommittee's report will go to the ACD for its recommendation. The staff will consult with Dr. Branche, Dr. Perkins and Ms.? Dr.? Priscilla Holman to accomplish that as soon as possible.

Several recommendations were summarized:

- The Subcommittee recommended that the Goal Action Plans and the preamble to the objectives return to the Subcommittee for its review.
- The action plan groups listed in B (race, ethnicity, gender, etc.) should be specific to the communities, not just a generic statement regarding disparities.
- With priorities introducing every goal, the Goal Action Plans should be targeted and specific for the Hispanic, African-American, etc., communities (listed in B), because the disparities are different for each group. Having more specific items will be critical to make this document more useful.
- Organizations in the minority communities will be invited to comment on the current starter objectives.
- The phased goal teams will identify issues (bottom of page 3) between now and mid-December, along with drafting the Goal Action Plan, action items, etc.
- Adding "future disparity" to the 2x2 table was also suggested by Ms. Bouye.
- The goal team leads' data review will be part of the assessment, to determine where disparities are and to target that in the Goal Action Plan.
- The global health community has good relevant models that should be consulted. Close examination and perhaps modeling on their use in settings was suggested. The latter encompass place and respect for the assets' authenticity, in a way that U.S. knowledge does not (e.g., health agencies entering a community work in true partnership with the community's assets). This Subcommittee should push for this collaboration in designing the question, developing and tracking the methodology, etc. In a related vein, the addition to the objectives of protective factors was urged. Assets are not included in the traditional biomedical or epidemiological model in the U.S.

and with immigration, being culturally appropriate becomes even more pertinent. It was agreed that this should be a future activity for this Subcommittee, to examine those models and work toward a recommendation for a future CDC agenda.

Closing discussion

The Goal Action Plans should reflect CDC's response to the Subcommittee's suggestions and how they were integrated to the plans. The planning stages go through December and the execution stage will follow management retreats in early February. After the input process is over, the staff will sift through all the input to determine what the criteria should be on which CDC will base its work decisions.

Since an ACD meeting is unlikely this year, an ACD presentation will probably be done electronically. That will be arrange by Dr. Gerberding's chief of staff, Dr. Lynne Austin. A teleconference meeting is planned before Thanksgiving (week 1 or 2 of November) to update the Subcommittee, especially regarding the availability of the Goal Action Plans for its review. A final Partners' Meeting will be held in March 2007, similar to the one held in March 2006, to review all the activities between the start of public engagement and Goal Action Plan rollout.

Dr. Williams thanked everyone for their participation and then, with no further comment, the meeting adjourned at 4:00 p.m.

Attachment #1: Attendance

Subcommittee members present over the course of the meeting were:
Dr. Georges Benjamin
Dr. Phillip Bowman
Dr. Moon Chen
Dr. Fleda Jackson
Dr. Mary desVignes-Kendrick
Dr. James Rimmer
Dr. Elena Rios
Dr. Jason Schneider

Participating by telephone were:
Dr. Antronette Yancey, Subcommittee Co-Chair
Dr. Adewale Troutman, Subcommittee Co-Chair

Subcommittee member Dr. Linda Burhansstipanov was absent.

CDC staff members present were Karen Bouye, Priscilla Holman, Pelagie (Mike) Snesrud, Patricia Thompson-Reed, Ben Truman, and Julie Wasil.

Attachment #2: Raw scores (%) for the 80-objective prioritization vote

Objective	Score (percent in favor)
1.	63
2.	38
3.	57
4.	13
5.	0
6.	38
7.	57
8.	75
9.	43
10.	13
11.	38
12.	0
13.	75
14.	13
15.	50
16.	50
17.	25
18.	25
19.	38
20.	63
21.	50
22.	43
23.	13
24.	25
25.	25
26.	50
27.	25
28.	63
29.	25
30.	25
31.	0
32.	25
33.	25
34.	25
35.	38
36.	38
37.	38
38.	63
39.	75
40.	13
41.	13
42.	100
43.	22

44. 50
45. 25
46. 13
47. 0
48. 13
49. 25
50. 50
51. 13
52. 13
53. 38
54. 25
55. 0
56. 13
57. 50
58. 0
59. 0
60. 50
61. 13
62. 50
63. 38
64. 50
65. 63
66. 13
67. 25
68. 38
69. 38
70. 25
71. 0
72. 13
73. 0
74. 25
75. 13
76. 38
77. 0
78. 0
79. 50
80. 75