SUMMARY REPORT

Taking Research to Practice: An Exploratory Meeting

July 21, 2006

Prepared by the Exploratory Meeting Planning Committee
September 1, 2006

Department of Health and Human Services
Centers for Disease Control and Prevention

Executive Summary

In a one-day meeting, 60 participants, representing varied public health sectors, discussed the issues of taking research to practice. The meeting's purpose was to identify approaches to effective dissemination of adoptable interventions and to define the roles of public health partners in dissemination. The group reached several conclusions; five key recommendations are summarized below.

- Assign the Centers for Disease Control and Prevention (CDC) the lead in developing and supporting the systems and mechanisms needed for widescale dissemination of effective interventions.

- Involve all public health partners in dissemination and ensure that each one's role is clear.

- Define the vocabulary of dissemination and adoption of interventions so that partners can effectively communicate with each other.

- Develop a long-term vision for the adoption of proven interventions that includes support for dissemination research.

- Create a single portal to information that gives practical steps for adopting interventions that can be accessed by researchers and practitioners.

Believing that concrete attention to these issues is long overdue, the participants urged immediate action on these recommendations.

Introduction

Background

The Directors of Health Promotion and Education and CDC's Prevention Research Centers Program convened a one-day meeting on July 21, 2006, titled "Taking Research to Practice: An Exploratory Meeting." A group of 60 invited participants engaged in discussion at the CDC Global Communications Center in Atlanta. The participants represented state and local health departments, professional associations and organizations, CDC publications, selected Prevention Research Centers, and divisions of CDC's Coordinating Center for Health Promotion as well as the National Center for Health Marketing, the Office of Public Health Research, and other CDC units.

The purpose of the meeting was to explore the issue of taking effective interventions to scale, using widespread dissemination, to have an impact on public health. The goals of the meeting were as follows:

- To identify approaches to effective dissemination of adoptable programs.
- To define the roles of different public health partners in dissemination activities.

The meeting included brief presentations and reactions, but most of the participants' time was spent in small group discussion, group reports to all attendees, and a large group facilitated discussion to summarize the key messages of the day and identify next steps. A planning committee established sets of discussion questions in advance.

A verbatim transcript is available for all portions of the meeting that involved the entire group, and copies of ad hoc notes from the small group discussions are available as well.

The meeting was prompted by participant groups' recognition that unfulfilled needs were being repeatedly expressed and that a formal discussion among groups might address those needs. In particular, staff from health departments regularly ask researchers for help in identifying effective interventions for dissemination. The practitioners ask for guidance on how to disseminate and facilitate the adoption of proven interventions. CDC and the public health community may be missing opportunities to have a positive impact on population health.

Content and Organization of Report

This report summarizes the main points from the small group discussions and the final large group discussion. Its content was reviewed by the meeting's planning committee and selected consultants. The report has three sections of comments and three appendices.

Small Group Discussion 1 Questions and Issues

Describes the combined issues identified and discussed by five groups in addressing the same set of questions during the morning breakout session.

Small Group Discussion 2 Questions and Group Reports

Summarizes the comments made by each group in discussing different sets of questions during the afternoon breakout session.

Summary Points and Next Steps

Collects the overall main points that emerged from the group discussions.

Appendix 1: **Meeting Agenda**

Appendix 2: **Meeting Participants**

Appendix 3: **Planning Committee**

Small Group Discussion 1 Questions and Issues

Introduction

This section describes the main issues identified by participants during the morning breakout session. Each of five groups addressed the same set of questions; however, each group tended to take its discussion in somewhat different directions, depending on the composition of the group, the degree to which the facilitator tried to direct the discussion, and other factors. As summarized here, the issues may not represent *consensus*, but the issues selected by each group for reporting to the entire group of participants appeared to reflect *majority* thought.

Questions

What are the key issues we need to address to disseminate proven strategies?

- What criteria can be established to identify interventions for recommendation to public health agencies and their partners?
- What level of effectiveness must an intervention achieve before it is considered ready for dissemination?
- How do we balance rigorous review against the need to promote promising interventions for further testing and translation?
- Should the same standards be used across all diseases, conditions, and risk factors? If not, how should they differ?
- Discuss benefits of developing a systematic approach to the adoption of public health interventions.

Issue: Acknowledge complexity but do not let it impede progress.

Several groups commented on the complexity of the topic of dissemination itself and how discussion must occur within the context of systems challenges—and ultimately, systems change. The challenges mentioned included narrowly focused funding streams, different incentives for different players, and the political climate at all levels of government.

Two groups explored the issue of complexity in further depth. Participants in these groups asserted that dissemination is a shared responsibility of all sectors (e.g., research, community, and the public health system) and that many factors come into play. Some factors mentioned were professional development (e.g., how a better trained work force would be better equipped to select and disseminate interventions) and marketing (e.g., how information is packaged and promoted has an effect on how well it diffuses). These groups noted how funders need to acknowledge and be responsive to all the components and stages of research development as well as people and communities.

Thus, participants were well aware that the topic is multifaceted and has implications to education, research, and practice. Knowing that the discussions would be imperfect, the participants chose to set aside the overarching complexities and to delve into the particulars, although systems challenges continually reemerged in discussions.

Issue: A common vocabulary is needed.

One group suggested that the very word "dissemination" is off target and that the word "adoption" should be substituted. The discussants in the group agreed the concern is not whether an intervention can be disseminated but whether it can be adopted.

All groups touched on some issues of language, and participants seemed unanimous that the descriptive language for communicating about public health interventions needs to be clarified and consistently used. One group asserted that consistent criteria and consistent language are a benefit of a systematic approach to translation and dissemination. Participants agreed that establishing evaluative criteria to communicate an intervention's or program's stage of development would not be possible unless consensus is reached on what terms such as "effective" and "disseminate" mean.

For example, some participants interpret dissemination as informing practitioners about the availability of an intervention. Other participants believe dissemination implies making all the tools available to implement the intervention. Thus, given these two perspectives, saying that an intervention has been disseminated implies different levels of effort to different people.

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Issue: Moving research to practice is a question of balance.

All groups ultimately discussed issues of balance and flexibility around scientific rigor, standards and evaluative criteria, practical or "real world" considerations (such as community preferences), and stage of disease prevention for which an intervention is designed (e.g., disease management vs. primary prevention).

While a few researchers or scientists involved in the discussions appeared reluctant to relax adherence to strict values of scientific evidence, most participants seemed to accept several assertions:

1. A community may not value the research in which an academic institution is engaged.
2. Policymakers may not think about science when making decisions.
3. Standards of rigor and effectiveness are not necessarily as relevant to health departments as to scientists; in health departments, a greater concern may be, for example, cost.

No one suggested that quality science was insignificant. However, attendees wanted to guard against academic and public health researchers being sidelined because of

"paralysis" or inaction that can result from "never-ending research" that fosters an inability to make decisions or recommendations.

The gap between the research community and the practice community was well illustrated whenever the *Guide to Community Preventive Services* (The Community Guide) was mentioned. One group maintained that the guide is "known as the scientific forum for effectiveness." These participants stated that the guide is the gold standard of the acceptable level of evidence and that a goal of dissemination efforts should be to build from the guide. However, all groups articulated limitations of the guide:

1. Not everyone *knows* about The Community Guide.
2. To actually disseminate an intervention, much more information is needed than what is given in The Community Guide; the guide does not provide *guidance*.
3. The Community Guide does not address costs—for example, training costs.
4. Lessons can be learned from programs that the public loves but scientists deem ineffective.
5. Basic research to replication can take 20 years; additional time is used to assess interventions, yet the goal is to put into practice findings known to work and as fast as possible.

Indeed, balance between rigor and speed seemed to be the crux of the matter in several discussions.

Issue: A repository of promising and effective interventions is needed.

Temporarily putting aside the issue of terminology, definitions, and rigor, all participants acknowledged practitioners' need for quick and easy access to a resource that includes

- Information about promising and effective interventions
- Tools for implementing the interventions cited
- Guidance on how to implement them.

This repository was variously referred to as a listing, a tool kit, a matrix, a clearinghouse, and a database. The proposed nature of its content also varied, but participants tended to agree that a resource has to include a lot of information that is not merely descriptive.

One group conceived of this repository as follows:
"…sort of 'consumer guide' kind of index that would list various strategies and talk about the level of scientific evidence, the level of reach, the level of adoptability…from which stakeholders…could pull…or [could use to] compare and select interventions from."

The same group would structure the index along a broad set of criteria and characteristics that indicate the status [or stage of development] of an intervention and enable stakeholders to make their own decisions.

Similarly, another group proposed a resource with sufficient background information and details on ingredients for success so that practitioners can make informed decisions.

Some ingredients included tools (such as manuals), technical assistance, and appropriate evaluation criteria. This group articulated the benefits of such a resource, which included sparing the researcher who developed the intervention from interference with new work and making it possible for practitioners to make one inquiry or one call to get everything they need for implementation.

Several groups suggested that the resource would have to be well advertised so that researchers contribute their work and practitioners know where to find it.

The idea of a repository was revisited at other times during the day and is addressed again later in this report.

Issue: Economic concerns need to be recognized and addressed.

Nearly all groups recognized the need to address the economic or cost issues of dissemination and implementation. Participants agreed that cost-benefit data or use of data to "make the business case" is insufficient. Participants were unanimous that scant funds are the reality at local and state health departments. Therefore, practitioners need to know the actual cost as well as the opportunity costs of choosing to implement an intervention. Cost data need to take into account not only the cost of purchasing the materials used to implement an intervention, but also the cost of staff time for training and implementation, establishing and nurturing partnerships, adapting an intervention to a specific community or location, and using ineffective practices.

Issue: The process of research to dissemination is a continuum, and both funding and research mechanisms need to support *every* step in the process.

Several groups noted that (1) current funding for intervention development and dissemination is not available for all stages or (2) mechanisms (such as networks) that could take responsibility for certain stages do not have sufficient resources.

For example, one group suggested that adoptability—not feasibility—is the endpoint and that to determine true adoptability, ongoing, systematic evaluation is needed in multiple settings. Yet funding is lacking for these kinds of evaluations; thus, the research to practice process is essentially cut short. Moreover, evaluation of interventions at various development stages also seems inadequately funded.

From its discussion of the same issue, one group suggested new mechanisms to "fast track" the evaluation of promising interventions. These participants conceived of a network dedicated to conducting efficacy and then effectiveness trials, appropriately funded to bring interventions to fruition.

Another group suggested that public and private funders should be periodically brought together to discuss funding gaps and to consider how different organizations can focus their resources on specific stages of the continuum.

In brief, nearly all participants proposed the need for creative thinking about how to administer the research to dissemination process and the funding of it.

Small Group Discussion 2 Questions and Group Reports

Introduction

This section summarizes the oral reports made by each group to convey the issues discussed during the afternoon breakout session. Each of five groups addressed different sets of questions. The text that follows each set of questions below captures the highlights of the discussions. Some common themes emerged across the groups, and these topics form the basis of the recommendations provided later in this document.

Group A Questions and Report

As a practitioner, what information do I need to ensure a program is right for my constituents? How do I find out about programs and other interventions (and what would be my ideal source)? How do I ask my questions?

The participants in Group A predicated their discussion on the importance of a practitioner (whether an individual provider, community, or state agency) being very well informed about its constituents and *their* priorities. Information about an intervention would then be needed to assess fit.

The following are among the basic questions to which the participants think practitioners would want answers:

- What demographic characteristics define the population in which an intervention was implemented, and for which setting is it intended?
- Which core elements of the intervention are crucial to replicate it with fidelity sufficient to ensure impact?
- What contextual factors might have affected the intervention?

A second level of questions included the following:

- What is the cost in terms of time, training, displacement of competing priorities, and actual dollars and cents?
- How much of an impact could be expected and would it lead to significant public health impact?
- What tools are associated with the intervention to determine community readiness and to evaluate impact?
- Did any unintended consequences occur when the intervention was previously implemented?

Concerning how to find out about programs and interventions, the discussants largely mixed the real and the ideal. However, it appeared that *none* of the resources mentioned would actually provide the detailed information sought.

- Use sources such as the Cochrane Database of Systematic Reviews and The Community Guide (despite the limitations articulated in the morning session).

- Rely on the Web sites of professional associations and their major journals.
- Call on academic and public health colleagues.
- Develop a mechanism, akin to the pharmaceutical industry's application of "academic detailing," in which a cadre of professionals would be tasked with making individual visits to practitioners to promote programs and packaged interventions.
- Encourage funders to cite evidence-based interventions when issuing a request for proposal.

In summary, the participants were seeking a single, primary source that would (1) be searchable, (2) provide a menu of options, (3) link to other sources, and (4) provide sufficient information for adaptation of an intervention.

Group B Questions and Report

How could state health agencies' policies and programs assist in the dissemination of proven strategies? How could CDC policies and programs assist in the dissemination of proven strategies? What is the best way to get a proven intervention packaged for wide dissemination and implementation?

The discussants in Group B addressed the questions but added that to advance policies for dissemination, not only are state health agencies and CDC involved, but also researchers, funders, and partners such as organizations and foundations. Each entity has some responsibility in dissemination and implementation, as noted in the group's six broad recommendations.

- Recognize that from concept to implementation, prevention research costs money. Because vast new funds are unlikely, resources need to be reallocated so that all stages are supported. CDC and other funders need to invest not only in discovery but also in dissemination research, intervention packaging, and widescale dissemination.

- Insist that researchers "get practical." Direct researchers to think about dissemination from the earliest stages of design. Encourage researchers to refine interventions and make choices so that adoption is *easy* for state or local agencies or community-based organizations in terms of cost and other practical limitations.

- Create a freestanding unit responsible for providing and supporting promising and adoptable interventions. Enable this unit to package interventions or supplement its resources with a clearinghouse that links Web sites, provides tools, and performs similar functions. Involve CDC and partners—such as foundations and associations—so that each takes a role in establishing and maintaining this unit.

- Actively promote interventions (through mass media, Web sites, lists of endorsed practices) so that they are known not just within research circles but also by policymakers, coalition members, and the general public.

- Use documents such as requests for proposals and listings to encourage adopting evidence-based practices. Allow for options and provide tools so that interventions can be readily tailored to different audiences.

- Educate state and local health agency staff on the importance of using evidence-based interventions and train them to appropriately modify the interventions.

Group C Questions and Report

From a *researcher's* perspective: What are the barriers to translation, dissemination, adoption, and institutionalization? Are there common barriers impeding these actions or do they differ by intervention, setting, and other characteristics? What facilitates these actions?

This group cited three main barriers:

- Conducting community-based participatory research on a timeline.
- Characteristics of the academic culture.
- Lack of leadership for the activities of translation, dissemination, adoption, and institutionalization.

According to the discussants, a contradiction is inherent in community-based participatory research. Substantial time is needed for researchers to build trusted relationships with communities. This barrier interferes with not only the original research but also the subsequent steps of translation, dissemination, and adoption in the same and other communities. However, funding for such work comes with time limits. Work may be either abandoned before it is complete or, in the interest of time, not be done "right." For either reason, an intervention may not have staying power.

The group equated researchers with academics and described characteristics of the academic culture that discourage the long-term investment needed for an intervention to be institutionalized. Some characteristics mentioned include the following:

- Rewards are given for exacting research designs, precise methods, and precise measures rather than a "big picture" perspective.
- Rewards are given for publication in peer-reviewed journals.
- Financial rewards are lacking for activities that fall outside a traditional academic role.
- Training for translation and dissemination research is lacking.
- Investments are made in intellectual property, not the free distribution of methods and tools.
- As an academic field, dissemination research is not well defined, not assured of long-term funding, and therefore not attractive to junior researchers.

The group noted that leadership for dissemination is lacking and suggested that CDC provide such leadership.

In addition, the group suggested several possible incentives:

- Make long-term commitments to funding research and researchers.
- Build relations with partners—such as foundations and businesses—that have money and influence.
- Market interventions and divide responsibilities among sectors.
- Educate partners about the time commitment required for research and dissemination.
- Sustain journals that publish articles in areas such as dissemination research.

Group D Questions and Report

From a *practitioner's* perspective: What are the barriers to translation, dissemination, adoption, and institutionalization? Are there common barriers impeding these actions or do they differ by intervention, setting, and other characteristics? What facilitates these actions?

While Group C cited a culture divide as underlying the barriers, Group D mentioned differences not only between cultures but differences within practitioners' systems. For example, participants noted that the public health system is organized differently in each state and that no single system is established for dissemination. In part, the group echoed Group C's comments on lack of leadership for dissemination.

Group D articulated only one real facilitator: easy access to information about interventions and how to disseminate them.

The barriers the participants cited included the following:

- Public policy tends to divide issues as health and non-health, and the latter tend to be considered higher priority and garner the resources.
- Local public health agencies are insufficiently staffed, the staff is insufficiently trained (e.g., universities train researchers), and practitioners become frustrated with bureaucracy and then discouraged.
- Public health practitioners tend not to reach out to diverse partners (such as businesses) and tend to use terms nontraditional partners do not relate to.
- Geographic isolation at the local level fosters a lack of awareness, and local access to new technology (i.e., electronic media) should not be assumed.

Group E Questions and Report

What components are needed to implement an intervention? Who should be responsible for packaging an intervention so that it can be widely used? Can a

packaged intervention contain all the information needed to implement it? What is the best way to get a proven intervention packaged for wide dissemination and implementation?

The participants in Group E reported recognizing that a "systems approach" is needed to achieve wide dissemination of an intervention and to sustain it. In such an approach, the responsibilities of all contributors to an intervention are defined and linked. The contributors include the stakeholders who fund or participate in an intervention, the researchers who develop it, the practitioners who translate and implement it, the professionals who market it, and the specialists who evaluate it.

The group believes dissemination should be planned when designing an intervention and that comprehensive information and guidance should be provided to implement it.

Components mentioned include the following:

- Materials in various media.
- Methods and clearly defined steps that can be adapted for local use.
- Projected timeline for implementation.
- Required training.
- Required level of staffing.
- Required level of funding.
- Marketing plan.
- Evaluation plan.
- Intended outcomes.
- Suggestions on when and how to stop an intervention that is not working, and how to document lessons learned.

Group E believes that packaging an intervention is a shared responsibility that involves one or more champions, funders, researchers, and marketers. The participants stated that a distribution mechanism is needed as well as resources for consultation and technical assistance.

Summary Points and Next Steps

Introduction

This section summarizes the facilitated, large group discussion. As the participants contributed, the facilitator probed for reactions and asked the group to reflect on specific elements of the day's discussion. The combined information is presented here as a set of initial recommendations.

Recommendations

- **Identify leadership** for dissemination at the national and local levels. Have **CDC** accept responsibility for facilitating exchange among partners, distribution of resources, and building of structures needed for interventions to have nationwide impact. Hold CDC accountable for a commitment to these responsibilities.

- Similarly **expect leaders from professional organizations to participate** in advancing this issue.

- CDC must **recognize the need for dissemination research and take charge of systems** for identifying, implementing, disseminating, and evaluating interventions on a wide scale.

- **Sustain the momentum** of the meeting by creating one group or several dissemination working groups authorized to build on this report and **define a systemic approach or formal mechanism** for taking research to practice.

- Ensure that ***all* sectors are represented** (including the policy sector) in such groups as partners—for efficient **sharing and reallocation of resources**.

- Ensure that **experts in health education and promoting awareness figure prominently** in such groups.

- **Cultivate partnerships** with traditional and nontraditional organizations (e.g., businesses and national organizations) that have the capacity to disseminate effective strategies.

- While an overarching group is recommended, simultaneously **encourage each sector to immediately look for and take small steps** within its own setting that can link to or contribute to a large-scale system as it is developed.

- Charge the dissemination group with **crafting a long-range vision** for adoption of proven interventions.

- **Create a common vocabulary** so that conversations can continue in which all participants understand the language (even if it means letting go of personal preferences).

- Ensure that **CDC endorses and abides by the vocabulary and uses it** for making classifications and recommendations; create a separate CDC group to foster agencywide consensus, support, and application.

- **Create a single portal to information** on health promotion interventions that has at least the following characteristics:
    - Systematic selection criteria that **balance scientific rigor and practical considerations**.
    - Additions that are **timely** and information that is **up to date**.
    - Clear statement on each intervention's **status** or "stage of readiness."
    - Detailed and **synthesized information** so that practitioners can be flexible and make choices best for different settings and make necessary adaptations.
    - **Access to materials, methods, and tools** either through a single repository (e.g., clearinghouse) or by directing practitioners to appropriate repositories.
    - **Research results** sponsored by funders **other than CDC**.
    - **Technical assistance** available on demand.
    - **Marketed**.
    - **Easy to access** and not buried in bureaucracy.

- Define a **mechanism** so that the information on interventions is continually "fed" with results from **ongoing evaluations**.

- Charge the dissemination group with **choosing** a discrete set of interventions as a priority, **a test case, or springboard** for future actions.

- **Develop the field of translation and dissemination research** so that crucial features and modifiable aspects of interventions are known, as well as what components must be included in an intervention package. Encourage research **design with dissemination** in mind.

- **Demonstrate** that the day's meeting as well as the concepts discussed are of **value by moving forward** in specific ways.

Final Comments

Fields of study related to prevention research have documented and described what is termed the *diffusion of innovations*. Participants termed the outcome of this meeting a call for *proactive dissemination*. This effort includes collaborative, concerted efforts by

multiple partners to reallocate resources and market proven strategies that can improve the *nation's* health.

Appendix 1: Meeting Agenda
Taking Research to Practice: An Exploratory Meeting

Sponsored by
Directors of Health Promotion & Education and CDC's Prevention Research Centers Program

CDC Global Communications Center
July 21, 2006
8:30 a.m.–4:45 p.m.

Purpose: This meeting will explore the issue of taking effective interventions to scale, through widespread dissemination, to have an impact on public health. The meeting goals are as follows:

1. To identify approaches to effective dissemination of adoptable programs.
2. To define the roles of different public health partners in dissemination activities.

AGENDA

8:30 a.m.	Assemble – Continental Breakfast – Room 254
9:00 a.m.	**Opening Remarks –** Room 108 *Jim McVay, Directors of Health Promotion & Education* *Janet Collins, National Center for Chronic Disease Prevention & Health Promotion*
9:15 a.m.	**Research to Practice: One Prevention Research Center's Experience** *Jeff Harris, University of Washington, Health Promotion Research Center* **Reactions:** *Eduardo Simoes, Prevention Research Centers (PRC)Program* *Heidi Keller, Washington State Department of Health* *Geri Dino, West Virginia University, Prevention Research Center* *Jim McVay, Alabama State Department of Health*
9:55 a.m.	Logistics **–** *Pam Eidson, Directors of Health Promotion & Education*
10:00 a.m.	—Break—
10:15 a.m.	**Structured Small Group Discussion 1 –** Breakout Rooms
11:30 a.m.	**Group Reports: Top Recommendations –** Room 108 *Jo Anne Grunbaum, PRC Program*
12:00 p.m.	Lunch – Room 254
1:00 p.m.	**Dissemination Approaches of Selected CDC Programs –** Room 108 *Kathi Wilson, Division of Cancer Prevention and Control* *Russell Sniegowski, Division of Diabetes Translation* *Lazette Lawton, Division for Heart Disease & Stroke* *Leandris Liburd, Division of Adult & Community Health*
1:30 p.m.	**Structured Small Group Discussion 2 –** Breakout Rooms
2:30 p.m.	—Break—
2:45 p.m.	**Group Reports: Top Recommendations –** Room 108 *Jo Anne Grunbaum, PRC Program*
3:30 p.m.	**Summary and Next Steps** *Adele Franks, PRC Program*

Heidi Keller and Jeff Harris

4:30 p.m. **Closing Remarks**
Eduardo Simoes, PRC Program
Frank Vinicor, NCCDPHP

Appendix 2: Meeting Participants

(in alphabetical order)

Vivi Abrams
Centers for Disease Control and Prevention (CDC)
National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
Division of Adult and Community Health (DACH)
Prevention Research Centers (PRC) Program

Mariela Alarcon-Yohe
Directors of Health Promotion and Education (DHPE)

Sheri Altepeter
DHPE, associate member
Polk County Minnesota Public Health

Tom Bartenfeld
CDC
Coordinating Center for Health Promotion (CoCHP)

Cynthia Boddie-Willis
National Association of Chronic Disease Directors (NACDD)

Julie Bolen
CDC
NCCDPHP
DACH
Healthy Aging Branch
Arthritis Program

Linda Bradley
CDC
NCCDPHP
National Office of Public Health Genomics

Carol Bryant
Prevention Research Center
University of South Florida

Christina Carillo
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Office of Health Promotion and Community Health Improvement

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Theresa Sipe
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Brandon Skidmore
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Suzanne Smith
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Bob Spengler
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Joan Stine
Maryland Department of Health and
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Esther Sumartojo
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Appendix 3: Exploratory Meeting Planning Committee

(in alphabetical order)

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