DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

State, Tribal, Local and Territorial (STLT) Workgroup of the Advisory Committee to the Director (ACD) of CDC

Summary Report
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Acronyms Used in this Document

ACD	Advisory Committee to the Director (CDC)
ASTHO	Association of State and Territorial Health Officials
BRFSS	Behavioral Risk Factor Surveillance Survey
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CPPW	Communities Putting Prevention to Work
FACA	Federal Advisory Committee Act
FOA	Funding Opportunity Announcement
FY	Fiscal Year
GHC	Global Health Center (CDC)
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
IT	Information Technology
LHD	Local Health Department
MCH	Maternal and Child Health
MMWR	Morbidity and Mortality Weekly Report
NACCHO	National Association of County and City Health Officials
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion (CDC)
OMB	Office of Management and Budget
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services (CDC)
OSTLTS	Office for State, Tribal, Local and Territorial Support (CDC)
PGO	Procurement and Grants Office (CDC)
PHAB	Public Health Accreditation Board
PPACA	Patient Protection and Affordable Care Act
PRC	Prevention Research Center
PSR	Prevention Status Report
REACH	Racial and Ethnic Approaches to Community Health
RWJ	Robert Wood Johnson Foundation
SHA	State Health Agency
SMEs	Subject Matter Experts
SMO	Senior Management Official
STD	Sexually Transmitted Disease
STLT	State, Tribal, Local and Territorial (STLT) Workgroup
STLT	State, Tribal, Local and Territorial
TB	Tuberculosis

Introductory Remarks and Overview of Meeting Goals

David Fleming, MD
Director and Health Officer, Public Health – Seattle and King County
Chair, State, Tribal, Local and Territorial Workgroup of the Advisory Committee to the Director

At 8:40 AM, Dr. David Fleming welcomed the group to the meeting, and requested that attendees introduce themselves. Following the introductions, he called for any announcements from the group. Lillian Rivera, RN, MSN, PhD, Administrator, Miami-Dade County Health Department, announced the upcoming 19th Annual Sterling Conference on Memorial Day Weekend. The conference will include Chief Executive Officers (CEOs) from the private sector to examine healthcare reform issues and to consider how to apply medical quality and performance management concepts.

Dr. Fleming then offered introductory remarks. He emphasized that public health is in a time of crisis, but also it is a time of opportunity. The State, Tribal, Local, and Territorial (STLT) Workgroup has had a chance to make a difference. This workgroup advises the Director of CDC, Dr. Tom Frieden, and they have latitude in how they move forward on their charge. He explained that during this meeting, they would create a process for moving recommendations from the workgroup to a forum where they can be adopted by the Advisory Committee to the Director (ACD). The plan was to review recommendations regarding their charge from the ACD to provide initial advice to CDC regarding how to improve its working relationships and granting relationships with the OSTLTS community. He thanked the workgroup that has begun working on this charge. Their goal is to create a product to present to the ACD. They also planned to consider impacts that likely budget cuts will have on all of public health, and he asked attendees to think about their recommendations for public health priorities. Finally, they would hear from Dr. Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) regarding the consolidation of chronic disease grants.

OSTLTS Update

Judy Monroe, MD
Deputy Director, Centers for Disease Control and Prevention
Director, Office for State, Tribal, Local and Territorial Support

Dr. Judy Monroe thanked the attendees for their participation. She stressed that the Office of State, Tribal, Local and Territorial Support (OSTLTS) is in a developmental stage, and expressed her hope for the group's advice and input.

Recently, OSTLTS made changes to its structure. OSTLTS is placing Senior Liaisons throughout CDC and has been charged to form stronger alliances between CDC and the regional offices. They are engaging in cross-cutting work, realizing that they need to build bridges between science and capacity development and practice. Further, the office is placing an Associate Director for Tribal Affairs in the Office of the Director at CDC. She addressed the Prevention Status Report (PSR), which will be released to states at the end of February. Seven states have been heavily involved in the report's development. This report focuses on CDC's

Winnable Battles and includes recommendations from the Institute of Medicine (IOM). Dr. Monroe noted that Branch Chiefs report directly to her so that she can have a better, more in-depth understanding of work being done in the office. She also noted that accreditation efforts are also moving forward.

She requested feedback regarding best practices. OSTLTS created a "road map" to help them think about moving its products from evidence to practice [See Appendix A]. The "road map" begins with "Evidence of What Works," which includes the science that shapes recommendations in the *Guide to Community Preventive Services* (*Community Guide*), the *Morbidity and Mortality Weekly Report* (*MMWR*) *Recommendations and Reports*, and the *Vital Signs Report*. In order to ensure that science gets into the field, the first step is awareness. OSTLTS wants to do its part to raise visibility. One of their strategies is "Did You Know?," a weekly email with three bullet points on a given topic that drives readers to *Vital Signs* and the *Community Guide*. Another example of their awareness-building efforts is the *State Health Official Welcome Packet*, which highlights the *Community Guide*.

Dr. Monroe described *Vital Signs*, the monthly four-page publication from *MMWR*. In December, OSTLTS began hosting Town Hall Meetings via conference call on the *Vital Signs* publication. Recent subjects of the calls have included HIV, motor vehicle injury prevention, and cardiovascular disease with a focus on cholesterol. OSTLTS invited medical educators and physicians to join the calls on cholesterol and hypertension. The results were fruitful, so when it is appropriate, public health and medicine will both join these calls. Subject matter experts (SMEs) from CDC talk about the topic, and the calls include implementation "success stories" from the field. OSTLTS works closely with the Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), she noted, as OSELS creates tools, and OSTLTS reaches out to the field to help them use those tools.

Turning to another OSTLTS focus area, Dr. Monroe briefly described the Public Health Associate Program. There are 65 new associates who have been placed in the field, and feedback has been good. Fifty more bachelor-level associates will be hired. The process is open for health departments to compete for Associates.

OSTLTS is charged with grants optimization, and is taking into consideration efforts that CDC can make to have a better impact in the field, as well as a larger impact with its dollars. Discussing this charge, and having a better understanding of how CDC dollars are used, should be a significant part of the STLT Workgroup's deliberations. A related subject regards how to survive the current financial crisis.

In closing, Dr. Monroe invited suggestions and discussion regarding what OSTLTS should do in terms of their various efforts, how they should communicate, and other ideas. She emphasized the challenges that they face in the current fiscal climate.

Discussion Points

- Mary C. Selecky (Secretary of Health, Washington State Department of Health) commented that the turnaround time for states to offer feedback on the PSR was very short.

- Dr. Monroe replied that in the future, they would endeavor to offer more time for feedback on the PSR.

- Dr. Paul K. Halverson (Director of Health and State Health Officer, Arkansas Department of Health) clarified that the PSRs would be distributed to state health officials, not the Governor's Office. He also inquired about any planned follow-up after the reports are published.

- Dr. Monroe confirmed that the reports would go to state health officials. The PSRs have changed based on feedback they have received. Regarding planned follow-up, Dr. Monroe said that OSTLTS, Public Health Law, and the Robert Wood Johnson (RWJ) Foundation are assessing ways to provide technical assistance to states on policy issues. They intend to offer support, which will vary by state, after releasing the reports. Further, OSTLTS is interviewing for new Directors of Public Health Law.

- Dr. Eduardo J. Sanchez (Vice President and Chief Medical Officer, Blue Cross and Blue Shield of Texas) wondered whether the PSR is a public document. He noted that his state's State Health Officer is not in a position to "move the needle." Others would be better able to make the report visible and to formulate policy strategies.

- Dr. Monroe said that the PSR was intended for use as an advocacy tool. The states recommended that the report first go to the State Health Officers, and states may choose different ways to disseminate the report's information. In the future, the reports may be available on a website or in a public forum, but vetting is needed from the states before they proceed.

- Dr. Jonathan E. Fielding (Director and County Health Officer, Los Angeles County Department of Public Health) asked about plans to create a "Welcome Packet" similar to the one designed for State Health Officials for Local Health Officers.

- Dr. Monroe replied that a welcome packet for Local Health Officials would occur in Phase Two of this effort. She hoped that Local Health Officials were receiving the "Did You Know?" emails. The emails are sent to members of the National Association of County and City Health Officials (NACCHO) in the hope that they will forward the information to their contacts. Ms. Selecky pointed out that only NACCHO members would receive the emails, so some people are likely to be left out.

- Dr. Halverson wondered whether OSTLTS had considered implementing peer reviews of "promising practices." He noted that the process of naming "best practices" can be long. Frequently, best practices are published, but there is no dedicated follow-up to learn who is adopting those practices and whether they are being adapted and improved.

- Dr. Fielding asked about the OSTLTS goals of cost reduction—health care and preventive.

- Dr. Monroe clarified that the point aims toward greater efficiency in the system. Further, if their process works, they can reduce the cost of healthcare through prevention.

- Melissa Gower (Group Leader, Cherokee Nation Health Services and Government Relations) asked about the new tribal position in the Office of the Director, and whether it was a reorganization of a current position.

- Dr. Monroe replied that the position in OSTLTS was a Senior Tribal Liaison, and it was located within a branch in OSTLTS. That position is being eliminated to create the Associate Director for Tribal Affairs in the Office of the Director.

- Mr. John M. Auerbach (Commissioner, Massachusetts Department of Health and President, Association of State and Territorial Health Officials (ASTHO)) observed that OSTLTS had accomplished a great deal in less than one year, and thanked them for working to establish meaningful partnerships. He wondered whether the STLT Workgroup could play an active role as an advisory group, especially in considering budget uncertainties and other unpredictable factors that would arise in the coming months. He hoped that they could support OSTLTS, either as a group or on an ad hoc basis.

- Dr. Monroe welcomed that assistance and expressed her hope that they could convene calls for advice as needed, as long as it was within the scope of the STLT Workgroup's charge and aligned with the rules that govern these groups.

- Amy Loy (Senior Public Health Analyst, OSTLTS) confirmed that the vision of the group was to offer support and advice to ACD, and that giving this support to OSTLTS was within its mission as well.

- Dr. Fleming added that working groups also advise the Office of Surveillance, Epidemiology, and Laboratory Services (OSELS) and the Global Health Center (GHC). Those groups are working in two areas: 1) where they feel that official recommendations to be adopted by CDC would have value; and 2) in a more informal manner, giving advice to Directors. He then asked about the potential effect of budget reductions on the OSTLTS budget and the office's ability to carry out its mission.

- Dr. Monroe answered that because OSTLS is new, its budget is not robust. Budget cuts may, however, limit their growth.

- Dr. Fielding commented that states, tribes, local areas, and territories are united by budget issues. The STLT Workgroup could be helpful in making the case for the benefit of public health. Their work would not be advocacy, but they could work with NACCHO and ASTHO to focus on evidence of public health's benefits.

- Ms. Selecky said that ASTHO and NACCHO are working together, and broadening those efforts to include STLT Workgroup feedback would be beneficial.

Presentation of Recommendations to Enhance CDC Support to State, Tribal, Local, and Territorial Health Jurisdictions

John Auerbach, MBA
Commissioner, Massachusetts Department of Public Health
President, Association of State and Territorial Health Officials

Carol Moehrle, BSN, RN
District Director, Public Health, Idaho North Central District
President, National Association of City and County Health Officials

Ms. Carol Moehrle began by describing the charge put to the workgroup from the ACD by Drs. Monroe and Fleming. She and Mr. Auerbach co-led a group of five members of the STLT Workgroup to consider how the STLT Workgroup as a whole might generate recommendations in several areas for the ACD at their April meeting. The assignment was open-ended, focusing on how the current CDC cooperative agreements and grants work with state, local, tribal, and territorial health entities. They were asked to create action steps or recommendations on how to improve these processes. They were also asked to "look at the bigger picture" of policy issues. The group included the following:

- John Auerbach, Commissioner, Massachusetts Department of Public Health (Co-lead)
- Carol Moehrle, District Director, Public Health, Idaho (Co-lead)
- Bruce Dart, Health Director, Tulsa, Oklahoma
- Melissa Gower, Group Leader, Cherokee Nation Health Services
- Paul Halverson, State Health Officer, Arkansas

They held multiple conference calls, exchanged emails, and convened one in-person meeting in Phoenix, Arizona. Their timeline for a product was 60 days.

In order to assess current CDC funding characteristics, they began with the understanding that many types of cooperative agreements and grants come from CDC. Some of these grants and agreements are generalized, which can obscure differences and subtleties. There are numerous timelines with these programs, and they are not consistent. Further, project officers at times have uneven skills and approaches. The group also considered whether appropriation language requires categorical funding. Congress dictates these appropriations, not CDC. Few grant opportunities focus on social determinants of health or offer flexibility to address root cause issues. In the future, they hope that the changes and recommendations that they suggest can help focus grant and agreement programs to focus on social determinants of health and achieve Healthy People 2020 objectives and goals.

CDC operates in an environment of a recovering economy. Further, CDC is affected by efforts in Congress to repeal parts or all of the Patient Protection and Affordable Care Act (PPACA). It is likely that CDC will have further cuts to its budget. Funding decisions are shared and are not always within CDC's control. Some are determined by Congress, some by the Administration. The small group understood these limitations as they formulated their recommendations.

The current environment at the state, tribal, local, and territorial levels is affected by economic issues and budget cuts as well. Core public health efforts are at risk because of funding cuts, and hiring has slowed or is nonexistent. The public health infrastructure is fragile and has eroded with decreases in funding. Additionally, requirements from outside forces are increasing and are stressing the system. The workforce is aging, and there is need for continued training and education. Over the last few years, 20% of State Health Agencies (SHA) and 15% of local health departments (LHD) have been lost. Services and programs are being cut. Over one-third of SHAs and nearly one-quarter of LHDs have imposed furloughs or layoffs in the last year.

These factors at the CDC, SHA, and LHD levels informed the small group's discussions and recommendations. Before presenting the recommendations, Ms. Moehrle described a few caveats. Particular issues affect tribal and territorial funding, and the group felt that these issues should be addressed separately. Political and economic issues are constantly changing, so the small group suggested that the recommendations should be revisited frequently to reflect those changes. The small group also discovered that some issues were too complex to handle in a small group in a short turnaround time. The issues that they chose to address another time, or in another forum included the following:

- Eligible applicants for CDC grants
- The need for collaboration between SHAs, tribal entities, LHDs, and territorial entities on contract engagement, as the collaboration between CDC and the states
- Competitive versus formula-driven funding

Further, the group emphasized that these recommendations were a beginning to the conversation. They need to continue to "chip away" at the complex issues.

The small group developed a Vision Statement to guide their deliberations that included the following concepts:

- Funding should be targeted to the most pressing health needs of the nation
- Funding should provide pooled funding as needed, unconstrained by categorical "silos"
- Clear goals and objectives should have measurable outcomes
- The partnership between CDC and STLT entities needs to continue to grow and develop
- Evidence-based and community insights are important in work at the local level
- Funding should be long-term and reliable
- Funding should allow for critical expenditures such as infrastructure needs.

The small group discussed infrastructure needs, knowing that funding often does not have the flexibility to fund these eroding needs. The group defined infrastructure to include critical, indirect activities, which may include information technology (IT), communication, facilities, training, and general administration. Agency-wide needs are rarely considered in grants. Some allowable infrastructure needs are capped if they are directly tied to a program area, limiting agencies' ability to use them as needed. The group created four emphasis areas, or categories,

for the recommendations, including: Flexibility, Outcome-Focused and Accountable, Substantial Engagement, and Technical Assistance.

Mr. Auerbach then explained the small group's ideas regarding a process for the workgroup's discussion. The small group generated 26 recommendations across the four categories. He explained that following the presentation of recommendations, the full group would engage in discussion. The discussion would be open and would not necessarily end in a vote. They would not "wordsmith" or try to come to a consensus on every point; rather, the small group would hear the Workgroup's feedback, redraft the recommendations, and share the revisions for final feedback. The recommendations would then be submitted to Drs. Fleming and Monroe for their consideration and comments regarding how to raise the recommendations to the ACD.

He then explained the concerns that the small group had identified for the first category, "Flexibility." These included the following:

- ❑ Most grants and cooperative agreements are categorical in nature and focus on a particular health issue or disease entity. Each year, the general rule is to "start from scratch," identifying goals, plans, and outcomes for each of the grants.

- ❑ Allowable expenditures on these grants and cooperative agreements are confined to a particular area of work, with some exceptions.

- ❑ Expenditures tend to be focused on a specific area of programmatic activity. There is little opportunity to find common efforts that might have a positive impact across an array of different health concerns. For example, a focus on healthy eating and active living would have to be addressed separately in each categorical area, even if some of the efforts have a beneficial purpose for a variety of different approaches. Each project officer makes a separate decision in this area.

- ❑ Infrastructure is thought of as both program-specific and agency-wide. In general, infrastructure-related or indirect costs are allowable in grants, but are often capped at an insufficient level, and the only allowable infrastructure is directly related to the program goals and objectives. At times, necessary agency-wide activities are not allowable within a program-specific grant.

- ❑ At times, the interpretation of what is allowable in a grant is not clear. The interpretations can be made at the agency level, at CDC, at a particular sub-section of CDC, or individually by a project officer. Different states or localities may receive different advice.

- ❑ Opportunities for activities that cross jurisdictional lines are limited. For example, if a few states wanted to address an issue in a unified effort, few funding opportunities are available for them.

The recommendations under the "Flexibility" category included the following:

- CDC should work with Congress to achieve greater flexibility in the awarding of funds without categorical and other constraints imposed by Congressional language. CDC is limited by Congressional language, and the small group does not want to make recommendations to CDC that are blind to this reality.

- CDC should move to awarding grants with a bundled or integrated approach, rather than a limited categorical approach. This approach could include, for instance, having a blended Chronic Disease grant category. In other instances, grant opportunities could be population-specific. Flexibility will lead to a more effective response to health issues that is mindful of the pyramid of interventions.

- When funding cannot be blended, CDC should maximize the degree to which there is flexibility in using funds that might cut across categories. For instance, a project focused on healthy eating and active living could be beneficial for grants in heart disease, diabetes, and obesity. CDC is encouraged to pull project officers together, or even to have a single project officer, in order to have more flexibility in the way that grants are structured and expenditures are allowed so that activities can easily occur across grant areas.

- CDC should address the issue of infrastructure costs so that it is possible to incorporate a portion of agency-wide infrastructure costs within programmatic grants or cooperative agreements. IT funding is a good example of how this recommendation might work, as all agencies are changing their health information systems and reporting requirements are changing. Expenditures to accomplish these goals are incurred at the agency level, not the program level. In the past, each program developed its own IT system and its own means for gathering information. Agency-wide systems could better communicate with other entities, and building a portion of those costs into each grant would be helpful and practical. Further, greater flexibility is needed in capping those infrastructure costs, especially when there is a significant initial outlay of costs in order to build a foundation for the grant expectations.

- CDC should develop ways of encouraging innovative and new cross-jurisdictional approaches where possible. For example, several Southern states have discussed examining infant mortality issues and prenatal health concerns with a regional approach. There should be a mechanism to help counties, states, or other entities to work collaboratively.

- CDC should create a new appeal process in which challenges can be made quickly and without fault or penalty. This point relates to the earlier concern regarding different interpretations of which expenditures are allowable.

- An over-riding recommendation is that CDC support a more interactive process that favors openness and alternative approaches to program implementation.

Ms. Moehrle explained that under the "Outcome-Focused and Accountable" category, the small group's concerns included the following:

- In order to justify funding, clear evidence of beneficial outcomes must be demonstrated. Sometimes, it takes a long time to establish the science behind best practices.

- Best practices and evidence-based approaches should inform, but not limit, the work that is done.

- A "culturally sensitivity filter" is needed on best practices to ensure that they fit within different jurisdictions, such as tribes, different ethnic groups, or rural or urban areas.

- Sometimes promising or innovative practices are not eligible because they have not undergone the rigor of evidence-based testing.

The small group created a number of recommendations out of the above concerns, including the following.

- Incentives and support should be created for programs that focus on the social determinants of health in both the long- and short-term.

- Guidance is needed to balance the use of process as well as outcome measures.

- The public health enterprise should be considered so that goals are not just established by CDC or Congress. The federal, state, local, tribal, and territorial levels should work on the same objectives, measures, and metrics so that outcomes can be shown across the spectrum.

- The importance of having evidence-based criteria must be recognized, but also it is important to have respect for the community development process and the culturally-oriented best practices that are created where they are implemented: at the state and local levels. Community approaches may not be "best practices," but they can be effective, innovative, and culturally and ethnically sensitive.

- Public Health Accreditation Board (PHAB) accreditation is supported as a necessary measure of infrastructure investment. The PHAB standard will allow states and locals to show that their infrastructure is robust enough to support public health functions.

Mr. Auerbach described the concerns the small group expressed with regard to the category of "Substantial Engagement," including the following:

- Often from the design of grant programs through their implementation and evaluation, there is insufficient input from states, locals, territories, and tribal communities.

- Without sufficient input from these entities, they cannot operate as efficiently or effectively as possible. Sometimes, periods of adjustment need to occur after the funding has been released.

The recommendations for this category highlight different activities that would benefit from more substantial engagement from the STLT population, including the following:

- Whenever possible, the cooperative agreement approach is preferred to the grant approach. The definition of a cooperative agreement is more aligned with the idea of a partnership, with interaction between grantor and grantee, to achieve the desired outcomes. The grant approach includes less cooperative decision-making.

- Members of the STLT community should be drawn into the identification of health priorities and the feasibility of solutions.

- A collaborative effort should be promoted in setting goals and objectives beyond the current cooperative agreement approach.

- There are inconsistencies in the ways that cooperative agreements are released and implemented. Consistent principles should be applied to the cooperative agreement approach.

- STLT populations should be involved in the design of both formula and competitive grant programs. STLT communities should be involved in evaluating the appropriateness of the intervention selection and the assessment of the application capacity through issues related to sustainability.

- Input is also needed from the STLT population in identifying proposed criteria for grant review. Efforts should be made to determine how best to allow meaningful input in considering grant criteria.

- In this environment, it is important to create a business case for CDC's funding programs. The case should address the cost-effectiveness of the efforts and how the efforts result in the reduction of expenditures that would otherwise occur. STLT populations should be involved in making those cases.

- STLT communities should be invited to participate in program evaluation activities. In a difficult economic period, it is important to have strong evaluation activities that are developed collaboratively.

Ms. Moehrle presented the category of "Technical Assistance," noting that the concerns in this category were as follows:

- Current technical assistance in the mechanics of grants is strong; strength is lacking in program content and in best practices.

- There is a divide between research and practice.

- There needs to be a hybrid approach to technical assistance internally at CDC, and also with external technical assistance for STLT populations.

The small group recommendations for this category were as follows:

- Steps should be taken to ensure that project officers have the necessary qualifications to conduct program design, implementation, and evaluation. More expertise is needed in program content, rather than solely in grants management. There seem to be inconsistencies in project officers' training, orientation, and skill level.

- Project officers with knowledge of current and emerging best practices, and extensive understanding of diversity issues in the field, would be able to give assistance to STLT populations on those areas.

- Internal CDC resources are relied upon for technical assistance. It is also valuable to have external stakeholder organizations available for technical assistance that may be more hands-on.

- There should be continuous improvement of program effectiveness. A feedback loop will help them learn how to provide technical assistance better.

- Grants management should be coordinated with program technical assistance.

Ms. Moehrle noted that they might combine recommendations 25 and 26, as recommendation 26 focuses on the research base and acknowledges the need to link academic public health and all levels of public health practice.

In closing, Mr. Auerbach reiterated the small group's intent. Drs. Monroe and Fleming gave them an open-ended invitation to address a wide variety of different contract activities. Their first task was to make the assignment manageable, so they deliberately did not take on certain issues. These issues should be addressed, but the small group did not have the resources or capacity to do so. Therefore, he recommended that their discussion begin with the workgroup's input and observations on the 26 recommendations by category area. Then, they could discuss other issues that should be included in the next steps.

Discussion Points

- Ms. Selecky commented that it would be helpful if CDC staff were aware of the capacity changes that have taken place at the state and local levels. Past presumptions about how to interact with SHAs and LHDs are no longer valid. For instance, some officials are prohibited from traveling outside the state. The funding environment has changed. Dr. Monroe agreed that information should be shared on all levels. It is easy to forget that others do not know what they know.

- Dr. Sanchez made a comment regarding the first recommendation under the "Flexibility" category. Deborah Lapin, a former ACD member, worked with Jack Lord on a report to the ACD about the challenge of the budget process and CDC's budget structure. He felt that this report would be helpful. It was reported to ACD at Dr. Tom Frieden's first meeting as CDC Director. Ms. Loy said that she would retrieve the report.

- Regarding the second recommendation under the "Outcome-Focused and Accountable" category, Dr. Halverson commented that outcomes cannot always be achieved in the initial grant period, but they should focus on the processes that are shown to be effective. It is understood that they are moving toward outcomes, but attention should be paid to process.

- Regarding the third recommendation under "Outcome-Focused and Accountable," Dr. Halverson added that they hoped for explicit alignment between federal, state, and local goals. There is an impression that CDC has a set of goals independent from other agencies and groups in the field. While the "winnable battles" are important, thought must be given to how they fit with work at the state and local levels, and what type of collaborative process might be utilized to integrate strategies.

- Dr. Fleming asked whether there are already established public health system enterprise objectives, or whether they need to call to create them.

- Dr. Halverson answered that they do have goals. Healthy People 2020 goals included input from across the country and from various stakeholders. At the highest level, the objectives are set; however, he felt that they should "drill down" more specifically.

- Ms. Moehrle said that they do not need to create new objectives; rather, they need to agree on priority areas.

- Regarding the "Substantial Engagement" category, Dr. Halverson suggested re-wording the first recommendation to read "contract" rather than "grant."

- Regarding the "Substantial Engagement" category, Dr. Halverson added that the small group recognized the "rush to get the money out the door," which is frequently a reason given for not gathering substantive engagement or involvement. He suggested that they work proactively with CDC to develop mechanisms in advance of grant opportunities, in full consideration of procurement rules as well as conflict of interest prohibitions. They should ensure that sufficient expertise is available in advance so that stakeholders can be engaged early, often, regularly, and in a substantive manner.

- Dr. Sanchez suggested that a standing workgroup might be needed in this area. Stakeholder involvement could simply include engaging health departments, but he felt that there is a need to identify functional expertise for this purpose. People are needed with functional expertise, evaluation expertise, legal expertise, experience in finance at the state and local level, and more. Procurement issues exist at the state and local levels. A standing workgroup with this functionality can help all parties be better prepared to move quickly.

- Dr. Halverson agreed, noting that the small group had extensive discussion in these areas. They recognized that a great deal of pre-planning and careful selection would be required in a host of areas. The group needs not only program expertise, but strength in other areas. Further, the distinction must be made between program-specific knowledge and knowledge of health officers at every level.

- Dr. Bruce D. Dart (Director, Tulsa City / County Health Department) suggested that a new business model needs to be created to allow them to achieve health outcomes across the country. This new model will have to be accepted.

- Mr. Auerbach added that at CDC, there is unevenness in efforts to embrace some of these recommendations. Some areas have become more inclusive, where others have not. As states are releasing grants, they are uneven in their success at involving local health departments and community-based agencies. Looking at where these efforts have worked, and where potential conflicts of interest have been successfully identified, will be helpful.

- On the subject of improving "Technical Assistance" and the project officer system, Dr. Halverson noted that persons in this role might not be those who are currently considered to be project officers. They hoped for people with recognized expertise in the program area. These people could bring more value than officers who may know something about the program area, but who focus more on process.

- Dr. Fielding added that the current stimulus funding provides technical assistance from subject matter experts early in the process. He thought this model deserved careful thought. He expressed hope that they would discuss the flexibility issue, noting that "flexibility works both ways." They will have to decide what they are willing to cut in favor of flexibility.

- Dr. Sanchez said that not only are project officers variable in their skill levels, but also they vary in how they utilize resources within CDC. A project officer should be expert in how to mobilize resources to make a project work. One individual may not have all of the necessary talents.

- Dr. Halverson agreed that they may not need project officers, but instead need project experts or subject matter experts who bring value with technical assistance, focusing on how to deliver services.

- Ms. Selecky noted that the experiences of the Senior Management Officials (SMOs) could be a model to examine, given that this program was very effective.

- Dr. Dileep G. Bal (District Health Officer, Island of Kauai, Hawaii) commented that the caveats listed at the beginning of the presentation seemed moot. He recommended that the caveats be removed from the presentation, as they are addressed in the recommendations.

- Ms. Selecky observed that while the recommendations address program and technical assistance, they have not given much focus to financial aspects of these projects. There is a need for assistance regarding the complexities of these financial systems and structures.

- Dr. Halverson added that the gap is widening between public health practice and public health research and academia. He hoped they could create links so that schools of public health do not operate independently from the practice of public health.

- Dr. Sanchez suggested that the Prevention Research Centers (PRCs) are places where links between academics and public health practice are created.

- Dr. Halverson reported that $20 million of new funding is to be awarded this year for public health practice-based research. One way to address this issue would be not to award those monies to academic institutions, but to award the monies to state and local health departments. This technique "forces" an explicit partnership between the state health department and the academic institutions so that real issues that affect practice are being addressed. The approach has its problems, but it is an opportunity to focus on community-based public health.

- Ms. Gower said that she had created a page with eight specific tribal recommendations, which would be part of the written document.

- Mr. Auerbach noted that those recommendations were specific and helpful and would be brought to the attention of Drs. Monroe and Fleming.

Guidance for Refining the Recommendations to Enhance CDC Support to State, Tribal, Local, and Territorial Health Jurisdictions

David Fleming, MD
Director and Health Officer, Public Health – Seattle and King County
Chair, State, Tribal, Local and Territorial Workgroup of the Advisory Committee to the Director

During this session, Dr. Fleming suggested working through the recommendations to provide guidance and input to inform the small group's revisions. He congratulated the small group on their hard work in such a short timeframe, and opened the floor for general observations as well as input on specific categories.

General Observations

- Ms. Selecky commented on the use of the word "infrastructure," which raises many capacity issues on the state and local levels.

- Dr. Thomas Farley (New York City Health Commissioner) noted that many of the recommendations overlap with each other. They may have more impact if they are collapsed to have a smaller number of recommendations.

Flexibility

- Dr. Farley commented on the common concern that moving from a narrow, categorical grant to a more general grant brings with it the potential for losing advocacy that is often the genesis of grant funds. If all communicable disease areas are combined, for instance, then the tuberculosis (TB) advocates may no longer lobby Congress for TB funds. He did not necessarily agree with this assessment, adding that it is possible to maintain advocacy and maintain core activities. The concern of loss of advocacy will be presented. He pointed to Recommendation 6, concerning an appeals process. He disagreed with the recommendation, as he was concerned that establishing an appeals process would make the entire granting process too complicated and bureaucratic. He did not feel that an appeals process could be "quick and easy."

- Mr. Auerbach clarified that the recommendation did not refer to who was awarded the grant. Rather, their intent was to create a process by which grantees could shift funds into a different program area, if need be.
- Dr. Farley agreed, and added that the language “appeals process” sounds too bureaucratic. They want more flexibility in spending within categories.
- Dr. Halverson said that the small group discussed creating an appeals process using an ombudsman-type approach so that grantees could get an expedited review. If a response to an inquiry does not make sense, there should be a mechanism to appeal it quickly without jeopardizing future grants. They do not want to create a “super-structure” that will move slowly.
- Mr. Auerbach wondered whether the term “expedited review” would be preferable to “appeal.”
- Dr. Farley favored language to emphasize flexibility in how grant monies are spent. With more flexibility, an appeals process would not be needed.
- Regarding flexibility, Dr. Fielding was less concerned about a loss of advocacy, and more concerned about overall budget cuts that might reduce overall funds to increase efficiency. Without agreement on metrics and clarity regarding necessary resources, the situation lends itself to “slashing.”
- Dr. Farley concurred and noted that many attempts to cut budgets are on-going, so advocacy is needed to prevent cuts. He believed that they could maintain the needed advocacy within a more flexible structure, but reiterated that they must be aware of these issues and potential risks.
- Mr. Auerbach said that the small group felt that flexibility could be addressed within a blended grant mechanism that includes disease-specific outcomes, or outcomes that are easily tracked to an area of interest of a constituency. For instance, in communicable disease areas, required goals related to TB may be established. Metrics are critical.
- Dr. Fleming turned to Recommendation 4. Giving broad license to use resources for agency-wide infrastructure is an important, and is an age-old issue. At issue is a definition of “infrastructure” as well as the extent to which the federal government should pay for a majority of agency infrastructure, versus the support being a state or local responsibility. Broadening the ability to use federal dollars for infrastructure may enable state and local policymakers not to cover these areas. They should move in a direction that specifies where dollars should go, in a manner that does not enable a “swap-out” at the state and local level.

- Dr. Fielding agreed, adding that they should reach agreement on what "infrastructure" is. In general, he felt that federal funding should be contingent not only on maintenance of effort, but also on a minimum percentage allocation from the authority receiving funds. He felt that states and localities should have "skin in the game" at a level that does not change from year to year. Recognizing that this point was beyond the charge of this group, he stressed that it represents the other side of flexibility—shared investment.

- Dr. Bal said that a key issue pertains to the question: What do you spend the money on? Many state and local entities are "on the ropes" and are under pressure to bring in funds to use as a revenue offset for the General Fund. When discretionary monies are given, either state and local jurisdictions will make a philosophical commitment to public health, as opposed to other funding areas, or they will not make that commitment. He offered an example of cuts in programs in Hawaii. The private sector took over the responsibility. He was concerned that business models are used to abuse public health more often than not. Recommendation 4, therefore, should make it clear that funds should be used for the purpose that CDC intends and should not be redirected.

- Ms. Selecky recalled that funds for preparedness have been beneficial for her jurisdiction. The funds were broad and not tied to a disease. They realized that they needed capacity for quick reporting and needed to invest in electronic data and reporting systems. These systems benefitted the entire enterprise, including diseases and conditions such as hepatitis, TB, smallpox, and others. The definition of "infrastructure" is important, and she suggested that federal contributions to an agency's infrastructure could depend upon the percentage of the agency that is federal. Definitions of infrastructure will vary from place to place.

- Mr. Auerbach clarified that the small group's intent focused on the non-programmatic elements of an infrastructure that have a direct and definable relationship to programs, but are not program-specific. For example, if an IT system is required to be developed that is compatible with federal reporting systems and is uniform across programmatic areas, and there are no funds to support the effort, it will not get done. He offered an example of an HIV prevention grant from CDC in which his agency engages in work related to needle exchange. There are near-constant legal challenges to this program, and they retain legal counsel to deal with these issues. That lawyer would not be considered a "direct expense" in the CDC cooperative agreement, but if they do not have the lawyer, then needle exchange will cease. The definition of agency-wide infrastructure should not be so wide as to not be traceable to a specific function that is being purchased, but more flexibility is needed.

- Dr. Dart said that the issue boils down to the question: What is the cost of doing business? Grantees need the flexibility to use funds for the costs of doing business, linking the costs to line items so they can be specific about the costs of implementing and supporting grants and projects. "Infrastructure" not only is the cost of doing business, but it also adds accountability for identifying costs.

- Dr. Fielding noted that their budget submissions do not refer to "infrastructure." Instead, they refer to specific capacities and capabilities, defining specifically what they are.

- Dr. Halverson said that a number of factors relate to an agency's ability to be effective that are not directly program-related. He offered the example of policy development, in which an

injury prevention grant may include forming coalitions and passing legislation. His Injury Prevention Director cannot go to the legislature, so the work must be accomplished through coordinated policy development efforts at the Director level. It must be recognized that there are shared leadership responsibilities that make an agency function. He realized that a certain level of funding should come from states and local entities, but in reality, their budgets are being decimated. In this climate, states are going to decide whether to maintain their funding levels and support. If, for instance, the federal government decides to eliminate family planning, there will be no family planning in his state.

- Dr. Bal agreed, but returned to the notion of having “skin in the game if you want to play.” Responding to Dr. Halverson question regarding what to do if states do not want to play, Dr. Bal said that this issue comes to light with states opting out of PPACA. The extent of federal jurisdiction versus state jurisdiction in areas where health is a right and not a privilege will be determined by the courts. If all entities are “broke,” then they have to scale down their expectations, and states must have “skin in the game” or they should not play.

- Dr. Halverson said that by making cuts, many states are saying that they are not “playing.” At some point, they will need to point to a certain level of public health functionality that must be provided by someone, regardless.

- Ms. Selecky asked about Recommendation 7, noting that having flexibility regarding how to approach coalitions would be helpful.

- Dr. Sanchez said that looking at the “play or no play” issue in those terms means that states or entities are making decisions that affect people. States have faced situations in which decisions made by elected officials are not in the best interests of the health of the population. He proposed that grants include enough flexibility so that money can be allocated where needed in order to achieve public health objectives. At times, state agencies do not want to “play” in one program or another, despite a need. There should be a way to create a flexible system that has engagement with state health officers and stakeholders that helps develop a set of objectives about the people in the state, not necessarily the organization or prevailing ideology.

- Dr. David L. Lakey (Commissioner, Texas Department of State Health Services) concurred with Dr. Halverson’s observations related to flexibility. States cut programs as tax dollars decrease, and he was concerned about issues regarding maintenance of effort.

Outcome-Focused and Accountable

- Dr. Farley felt that the recommendations in this category indicate that grantees should be held accountable for outcomes of their work, and should have flexibility to achieve those outcomes. He suggested that the recommendations regarding balancing the use of evidence-based criteria and community-developed, culturally oriented best practices be collapsed into one statement.

- Dr. Fielding said that many people to whom they report do not understand public health, especially the outcomes to expect. Formalizing and coming to agreement on outcomes is important. Incentives are important as well. Evidence-based approaches are important for practice, and “community-developed practices” is a broad category. Clear logic models are often needed. In some cases, process measures will be intermediaries, but the process is

still outcome-focused. There is a difference between adapting an evidence-based practice for a particular circumstance, and just trying a practice that seems promising.

- Dr. James Nicholson (Nick) Baird (President, Stillwater Solutions LLC) valued supporting the evidence base. He also noted the tremendous value in the creativity and innovation of the private sector. Promising practices may not be evidence-based, but they can become so. Not allowing some of these practices to be implemented while waiting for peer review, for instance, misses an opportunity to engage in promising practices that may improve health earlier than waiting for a scientific base. He felt that there is a way to "marry" science with innovation and creativity, and he supported the balance.

- Dr. Rivera said that it is difficult to be outcome-focused and accountable in good times, especially at the local level. She turned to Recommendation 12, supporting the PHAB accreditation process. In these uncertain times, she was not sure whether health departments would engage in the process because they are focused on critical issues of survival. PHAB may be seen as an addition to their workload. However, uncertain times are the most important times to become more focused and accountable. These messages must be delivered through state organizations, and must go beyond support to encouragement and motivation.

- Ms. Selecky felt that supporting PHAB as part of infrastructure is as important as supporting PHAB accreditation. The accreditation process is a systemic assessment of how an organization does business, including finding opportunities for improvement. They should be careful that the recommendation is not read as a mandate.

- Dr. Bal supported Recommendation 11, balancing the evidence base with community-developed approaches. The translation of science to public policy is never as unequivocal as they would like it to be. He recalled an empirical tobacco intervention in 1990. It was a risk to implement it, but it worked. Many public health and medical advances began with empirical evidence.

- Dr. Fielding said that there are times when it is appropriate to act based on limited evidence, especially when a problem is of large dimensions. For example, they are acting in the area of childhood obesity without clear evidence of effectiveness. He noted occasions in which "innovative" approaches were used where evidence-based approaches were available and could have been used, and he hoped to avoid those situations.

- Mr. Auerbach agreed that some of the recommendations needed clarification. Some of the recommendations embrace the conversations taking place regarding the Community Transformation Grants, which are viewed as focusing on changing policy as opposed to metrics, and focusing on grassroots community involvement as a driving force behind decision-making. The first approach raises the question of the right metric. Now, grants and cooperative agreements tend to require a specific, quantifiable deliverable. This requirement is different from a policy change that could take three years to become successful. Recommendation 9 attempts to capture this shift. Recommendation 11 addresses the notion that involving community-level entities and telling them that their only options are evidence-based work. This will result in pushback from the community that their input was not really sought, and that they were only included to pick from a list of interventions. Communities know what works in their communities, and there should be

flexibility and respect for that knowledge as well as for what has been researched and studied.

- Dr. Fielding said that in his experience, providing “menus” has been helpful. Otherwise, efforts can go in any direction. Providing a “menu” with the understanding that the interventions can be tailored has made a difference by setting parameters and helping people start with a common base of understanding. The approach is useful and does not eliminate creativity and innovation, but channels it.

- Dr. Karen Remley (Virginia Health Commissioner) said that without local government and legislative earmarks or an evidence base, it is difficult to conduct projects. They need evidence that an intervention will work. She further noted that politicians are involved in how grants are distributed and the degree of flexibility they have. Without some requirement of an evidence base, she was concerned that the field would be wide open for legislators to earmark their own projects that may or may not be what is needed or effective.

- Dr. Dart recognized that external dynamics have changed and will probably continue to change, and he hoped that they would be responsive to the new environment. They need flexibility to adapt to changing dynamics and to continue to perform at the optimum level.

- Dr. Fleming suggested that the system was broken in this area partially because CDC is decentralized, so different parts of CDC deal with this issue in different ways, making it difficult at the state and local level to operate grants with different philosophies. He was convinced that there is a tension between being “outcome-focused” and wanting to be held accountable. It is not possible to do both at the same time in public health. Obesity is a good example. Nobody knows what obesity rates will be in five years if nothing is done about the problem, so it is difficult to be held accountable for an outcome if something is done. The effect sizes in different communities of proven interventions in tobacco are unpredictable and are different. There are no proven practices in obesity, so they need to be experimental. For many people, accountability centers around distal health outcomes that may take place years or decades down the road. He believed that they need to agree with funders and policymakers regarding the outcomes that they hope to change, while accountability is actually for the strategies being put in place. Ultimately, grantees should be held accountable for those activities that are agreed to be their “best shot,” deliver on those strategies and evaluating whether change is taking place.

- Dr. Fielding agreed, adding that Dr. Fleming’s point applied differently to different subjects. In obesity, for instance, syntheses of promising practices have been created. For TB or sexually transmitted diseases (STDs), they know outcomes. Another discussion concerns priorities for what they do. Should they consider preventable burden or other metrics? He commented on the underlying physical determinants, noting that social and physical determinants are long-term. Their strategies are important, and one of the problems with policies is that their success is measured by whether or not they are accomplished, not by “how hard they try.”

- Dr. Halverson said that as they agree to be held accountable for evidence-based strategies, it raises the need for increased, better, and more contemporary research in these areas. Frequently, they work at the limits of research that has been completed and that is not necessarily updated or contemporary to today’s challenges. There needs to be greater alignment between what is being done in practice, the study of evidence, and the

documentation of evidence to be modified over time. Public health practice research needs real strength and it needs to be robust enough to keep up with the practice. He was concerned that they would be confined to old practice and old research.

- Dr. Farley noted that the issue is terminology. States, locals, and CDC need to agree on the metrics that will define success. Some might call the metrics process measures, others might call them outcome measures. When the metrics are defined, then there should be flexibility to achieve them. In the area of TB, the metrics would probably be agreed-upon as treatment completion rates and contact treatment rates. In obesity, they could likely agree upon the most useful metrics to use, given the current state of knowledge.

- Dr. Lakey asked for clarification on the thinking behind Recommendation 8.

- Mr. Auerbach answered that the recommendation focuses on moving away from categorical, year-by-year work plans that assess grant success based upon concrete deliverables or outcomes that are received in a relatively narrow, discrete time period. The recommendation suggests replacing these work plans, where appropriate, with the notion of changing conditions in people's communities and lives, thinking about environmental change in which an effective strategy must be recognized where activities take place over a given year. This approach is a different way of defining an outcome. The outcomes may be related to establishing coalitions or drafting regulations and introducing them for the first time, in contrast to developing guidelines that are distributed to clinicians' groups or educational materials that are circulated.

- Dr. Lakey understood the importance of the recommendation, but cautioned them to articulate their outcomes carefully. He recounted a conversation with a legislator who saw these areas as "fuzzy." When the areas are "fuzzy" or "squishy," they can become vulnerable in funding allocations. Mr. Auerbach thanked him and noted that they would be sensitive to that point.

- Dr. Fielding said that the whole notion of policy is "squishy." Public health work includes agriculture, housing, and transportation. Some need convincing of these connections. CDC and the STLT community need to come together to recognize that the issues are public health, and how public health can have a role in them.

Substantial Engagement

- Mr. Auerbach suggested that they could collapse a number of the recommendations in this category.
- Ms. Selecky referred to Slide 27, noting that in her experience, subject matter experts have almost always been internal and CDC-focused. She hoped to bring more people "under the tent" and she hoped that the message would reach CDC personnel.
- Dr. Fleming observed that they were in agreement that CDC should better engage with the STLT community. The flip side of the issue is that the STLT community should be ready for that engagement. He asked for the group's comments on a process or mechanism for CDC.
- Ms. Selecky said that the regions are very different. She recalled Dr. Monroe's comments regarding engaging the CDC regional offices in a meaningful way. Perhaps a trial could be undertaken in a region, bearing in mind that there are different dynamics within regions.
- Dr. Fielding said that creating a standing group that could be called upon for rapid response, including representatives from different types of organizations, would be helpful. Trying to collect comments from the entire community, or trying to collect official comments, might not be the best way to approach the issue.
- Dr. Farley asked whether the main problem was a lack of response, or of conflicting responses.
- Dr. Fleming replied that the latter was more of a problem. It is often possible to predict the response that will be given by different people, so it is possible to choose a certain group to get a certain response. A pre-established, quick-responding group that synthesizes a number of opinions would be ideal.
- Dr. Farley said that setting up a structure is key to making the group doable.
- Dr. Halverson pointed out that key focus areas are known in advance. It would be possible to create a panel of people who could be called upon prospectively at first, but then on a reactive basis as necessary. If they really want engagement, they should design a mechanism that makes engagement possible. Waiting until the last minute to gather input will result in a predictable response, but thinking proactively by assembling state health officials, local health officials, program experts, and others who could serve in an advisory function, could provide perspective from the field. The group should be changed regularly to ensure that different voices are heard. There may be issues with Federal Advisory Committee Act (FACA) rules as well as with procurement and conflict of interest rules, but there should be a way to work within the confines of the federal rules to create this group.
- Dr. Fleming noted that many of these decisions are made outside of CDC by others in the federal system, so any input would be in the nature of an advisory group.
- Dr. Monroe asked whether any proactive group like this had been attempted in the past.

- Ms. Selecky replied that attempts were episodic. She recalled from her time at the local level that a group of people would be asked to weigh in on a given topic or direction. This group differed from what they were discussing.

- Dr. Bal said that such a group would be difficult to create, unless the group was large enough. The heterogeneity of the STLT community is significant and is stratified by a number of factors, areas, and perspectives. In order to represent the whole, opposing viewpoints must be included.

Technical Assistance

- Ms. Moehrle suggested that some of these recommendations could be condensed, as some seem to overlap.

- Dr. Monroe reminded them that OSTLTS is charged with improving project officers.

- Dr. Farley agreed with the problem presented by the category, but he was not fully in agreement with the proposed solutions. When he was at the state level, he was disappointed that he could not turn to his project officer for advice on how to handle problems with his project. The project officers were often young and inexperienced, and many had never worked at the state level. He hoped for a senior person who might be able to provide advice and suggestions. Such individuals may not be found in Atlanta, since many staff in Atlanta have spent their entire careers there. The most useful conversations he had when he was at the state level were with people in other states. Some manner of peer technical assistance system is more valuable than hoping to create a project officer system with officers who will be able to provide experienced advice. He suggested that project officers be as expert as possible, but they are not likely to achieve what they want by themselves.

- Dr. Monroe said that there were over 600 project officers at CDC, and it is possible that so many are not needed. Dr. Farley added that they have added little value.

- Mr. Auerbach said that two approaches were recommended. First, they recommended strengthening the project officer system as much as reasonable. Second, they note that project officers are not able to provide what is needed. It is important to commit to identifying external parties where the needed expertise may exist. This could take place through contracts with individuals or organizations, or via peer-to-peer networks. It does, however, need to be part of somebody's job to ensure that someone is available.

- Dr. Halverson said that using the label "project officer" might be a problem. The recommendations refer to receiving technical expertise from CDC. He agreed that the need was a hybrid. CDC has a responsibility to develop expertise in its subject areas, recognizing that not all expertise will come from CDC.

- Dr. Monroe noted that they recommended creating an "expertise system," not necessarily a group of experts.

- Dr. Halverson added that the government needs a procurement officer to deal with the grants, but these persons should not be expected to be technical experts. Decoupling these roles will allow the work to be accomplished with fewer people.

- Dr. Sanchez returned to his earlier comments regarding functionality versus job description. It is important to begin with asking what functions are essential for the enterprise, and then how to assemble a team to deliver those functions. Within CDC, are some working better than others? Are any states doing anything like this? Consulting organizations live with the challenge of organizing their resources with a project manager working within the assets of the organization. Can any lessons be learned from these organizations? Further, health plans administer their vast numbers of accounts with a system of account managers who know how to avail themselves of the needed expertise in clinical questions, for instance. These models, and others, may inform what CDC does to ensure that project officers are deployed in a manner that adds more value.

- Ms. Moehrle agreed that the team approach is critical. Experts are often found at the local level, because they are the ones implementing the best practice or evidence-based interventions. At times, the expertise and technical assistance is not found at the state level, but through NACCHO.

- Dr. Bal felt that the project officer system had been blown out of proportion, observing that the problem may not lie with the project officers themselves, but with the expectations of CDC. He never expected technical assistance from CDC, because public health interventions came from the field. Technical assistance came from other areas. He further noted that CDC's technical assistance depends on CDC leadership, especially regarding policy.

- Dr. Fielding pointed out that there are different kinds of technical assistance. For most grants, it is helpful to encourage grantees to work closely with their peers, given that they deal with similar problems. It would also be helpful to develop national experts who could be available. For major bureaucratic problems, technical assistance can come from colleagues and professional associations.

- Dr. Fleming observed that the group's comments reflected a degree of caution regarding whether they should strengthen or streamline the project officer system. In an era when CDC's budget is being reduced, and they will have to examine areas in which they are not getting value from their dollars, there was agreement that the current, very distributed project officer system seems to be taking more resources than it provides in value. With that in mind, they should be careful that this recommendation is not read as, "make more project officers," but rather that a smaller number of project officers could be assigned to jurisdictions to break down categorical barriers across grants.

- Dr. Fielding suggested a system of generic project officers. They could develop expertise in different areas. This approach is very different from the current model.

- Ms. Selecky was working in the area of reshaping public health, and one aspect of that work is "doing business differently." When there are reductions at the federal level, how will public health do business differently, and what is the definition of a project officer? So far, the project officer is the person assigned to the grantee for a contract or cooperative agreement. Preparedness grants were broad, so project officers had to learn quickly how the systems worked.

- Dr. Halverson suggested an approach that assigned one senior person to each state who could represent CDC in a number of project areas.

- Mr. Auerbach said that the issue of project officers could be addressed with the notion of blended grants and cooperative agreements. His state, Massachusetts, is one of the four that are piloting chronic disease integrated grants. They have half a dozen different grants and half a dozen different project officers, and the biggest impediment to their progress is the fact that there are six different officers with different perspectives. It would be simpler to have a single project officer for all of the grants who was cross-trained in the chronic disease agreement. The other states in the pilot program are Colorado, Wisconsin, and North Carolina. He did not speak on their behalf, but he surmised that the other states would agree with him in this area.

- Dr. Monroe compared these ideas to the medical model with a general or family practitioner who works in the medical home and who uses the resources of subspecialists when needed.

- Dr. Farley reminded them that people with the necessary in-depth experience at the state and local level are not likely to be found in Atlanta.

- Dr. Sanchez suggested instituting a six-week deployment at the state level for project officers so that they may have a sense of state and local systems. Further, a "project manager lead" could be created as a coordinator at the state level so that there is one go-to person.

- Dr. Baird asked about the SMO project and whether lessons were learned from it.

- Dr. Sanchez replied that there are lessons to be learned from the SMO idea and how it played out in practice. Those lessons could be applied to this new way of thinking, as the same challenge drove the SMO concept. Ms. Selecky added that reports about the SMO project were created.

- Mr. Auerbach said that the SMO program was costly, and a way of offsetting the cost of their proposed changes would be to have fewer project officers.

- Dr. Bal commented that the SMO system does not do the "meat and potatoes" of work. He noted the long timelines to get things accomplished, as the officials are at a senior level. He suggested that people at the state level could be helpful.

- Dr. Halverson clarified that he was not suggesting that the SMO model would work as it was implemented; rather, the model could be modified to include new duties.

- Dr. Remley commented that Dr. Monroe functions in this role for all of them. She has seen performance improvement. The more time spent in this realm, the more one learns about what works at the state level. The project officer model was strong when it was begun, with the intent that it was a starting point for CDC staff in their careers, but it is flawed because the role truly requires knowledge and expertise that a person beginning at the "ground floor" does not have.

- Mr. Auerbach said that the small group would be challenged to sort through the differences of opinions reflected in the workgroup's comments and reactions to the recommendations. He surmised that they would create a process that does not result in a "watered-down" product that tries to merge contradictory opinions. As they send revisions to the larger group, he asked them to think about how to finalize a report that does not have absolute consensus.

- Dr. Farley observed that the group agreed with 80% of the content of the recommendations, and he suggested that they focus on expressing themselves clearly.

- Ms. Moehrle was encouraged that the small group's work resonated with the rest of the workgroup. She thanked them for the rich discussion.

- Dr. Fleming thanked the small group members for their hard work.

Brainstorming Regarding OSTLTS Priorities

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Dr. Fleming indicated that the group's next task was to discuss how best to use their collective resources in the future to provide advice to OSTLTS and CDC. He asked Dr. Monroe for her thoughts regarding areas in which OSTLTS would most need advice.

Dr. Monroe began by thanking the group for their morning's work. She noted another product coming from OSTLTS and its partners—an online CDC directory for departments of health. She thought that the morning's discussion regarding project officers had been exciting and helpful, and they were already thinking about how to approach and redesign the system.

Other areas in which the workgroup's help was needed include:

- ❑ Policy, including public health law and technical assistance
- ❑ Managing the financial crisis in terms of what CDC should be doing
- ❑ How CDC might approach direct assistance
- ❑ Quality of field staff

Dr. Fleming asked each workgroup member to share suggestions and thoughts regarding how to spend the next six months, whether as recommendations for OSTLTS or for CDC via the ACD.

Discussion Points

- Dr. Baird said that it would helpful to get a sense of what the CDC and the Director see as doable or realistic, so they can know the agency's priorities.
- Dr. Monroe answered that the areas she mentioned were all priorities for Dr. Frieden. There is question, however, of what is doable and reasonable within certain timeframes. Dr. Baird said that they should focus on what they can really accomplish.
- Dr. Rivera referred to the areas of policymaking and managing the financial crisis. In her state, they have problems because it is not clearly delineated where health policy is made. The SDH is not heavily involved in health policymaking. The State Health Officer functions at the level of a Chief Operating Officer. She hoped that CDC would understand how policy is made at the state level. In terms of managing the crisis, she emphasized that CDC should have an understanding of what will happen in states that have new governors. She expressed uncertainty for her own state, pointing out that the new governor's philosophies regarding public health are not clear. Recognizing what will happen state by state will help CDC, but she was not sure how to get the information unless the State Health Officer communicates with them. She predicted difficulty in managing the financial crisis in the absence of the right data or information.
- Dr. Halverson suggested that they have a constructive discussion regarding the notion of the "enterprise" and the "system," including a discussion of the expansion or contraction of direct funding. How big is big enough? How small is too small? Other issues concern the states and territories and their relationship to the local health departments, and tribes' relationships. Another focus is providing direct funding from CDC while trying to create and maintain a system. He suggested that they create a framework to have discussions around these potentially divisive topics.
- Dr. Fielding agreed that they should discuss what the new health department looks like. Many different factors are affecting this structure, including health reform, the roles of accountable health organizations, how to interface given the "Meaningful Use" requirement, inevitable reductions in direct service provision, and increased capacities to do surveillance. Also important to consider is what role they should play in quality assurance for the medical system. Where are there voids? He felt they should also consider the role public health has in intersectoral work and the underlying determinants of health. He also offered the topic of combining the evidence base from population health with what is known from clinical work, both in prevention and in treatment.
- Mr. Auerbach suggested that they prioritize taking advantage of the possibility that they will keep the Public Health Trust. He hoped that they would think critically and collaboratively about the best use of those funds. Also, they should understand the implications of likely reductions in funding and how they will affect the way CDC works as an organization. This period is historic, and decisions made in the next 12 months will have long-term impact on the shape of CDC and its priorities.
- Ms. Moehrle said that they should assess the whole enterprise to determine where they are moving. ASTHO and NACCHO have had discussions about what public health should look like in these changing times, and these discussions should include CDC so that the continuum is pointing in the same direction. They can then agree on metrics or outcomes.

- Dr. Remley hoped that they would not use optimism and forward motion. The funding for public health prevention is not gone yet. She agreed with working on the concept of focusing state, federal, and local energy around the public health initiatives that lead to impacts that are visible to the public. They may have common themes, but they are also beset with real political issues, so they should choose key areas that are critically important and align policy around them. Her state's health department is an informal policymaker in that it provides recommendations around policy, but is not tasked with being the policymaker.

- Dr. Sanchez reminded them that CDC is part of the larger enterprise of the Department of Health and Human Services (HHS). They should appreciate that the priorities of the larger enterprise, to some degree, drive what they will be able to do. All health departments get funding from other parts of the larger enterprise, and he wondered whether as they work within CDC, other lessons might be learned for other pieces of the federal funding portfolio. He referred to "lumping" across categories and jurisdictions. For example, El Paso, Texas could work better with Las Cruces, New Mexico than with any other city in Texas. Many programs preclude that kind of conversation. Regarding project management functions, he reiterated that the job is not about a person, but about the elements that are needed to optimize the grant. He also raised the issue of portfolio management, perhaps state by state. If the Project Manager functions at a higher level, then the role will be portfolio management. The role is not only an information broker, but has the ability to make decisions at the programmatic level that could result in the reallocation of funds.

- Dr. Farley hoped that there would not be huge budget cuts in public health, but realized that there probably would be cuts. This group could help prioritize among CDC's public health programs, contributing insight from a broad perspective. He noted that there has never been a clear, agreed-upon national strategy in certain areas, such as chronic disease prevention. It would be helpful to create recommendations for how national strategies are developed with appropriate input from the STLT community and CDC. He felt that CDC was the best organization in the world in the area of epidemiology and describing health problems. However, that expertise does not translate to knowing how to solve the problems. Bringing expertise from outside CDC would be worthwhile, and this workgroup could assist in that effort. In his state, he observed that when budgets are collapsing, policy change represents a way to move forward, as policy change costs little or nothing. Most jurisdictions do not have the capacity to discover policies that could be put in place or to develop coalitions to advocate for them successfully. CDC could help jurisdictions develop that capacity. Creating a system for a range of expert assistance could help those with little capacity. There is a great deal of informal expertise and experience in implementation strategies around the country. Because of the high turnover at the state level, creating a system for sharing and transferring that information would be worthwhile.
- Ms. Selecky suggested starting with "low-hanging fruit." ASTHO Senior Deputies created a list of recommendations for CDC to consider. For instance, one of the problems with the grant and cooperative agreement program is that timelines are numerous and often unpredictable. CDC could generate common dates and agree upon them internally. She also returned to the issue of budget cuts and whether the Director's office would share a common message or recommendations for how to deal with those reductions. They should also consider immediate as well as long-term impacts.

- Dr. Monroe said that the top five “low-hanging fruit” recommendations from the ASTHO Senior Deputies were being worked through the Procurement and Grants Office (PGO). She said the process has been delayed, observing that even the “low-hanging fruit” has taken time. They hope to announce changes by the end of March.

- Dr. Dart appreciated that comments were coming from a systems perspective, and that they were thinking broadly along the enterprise. They have an opportunity to discuss what they realistically can accomplish, for instance, in rural America versus urban America where capacities are so different. Grounding their conversations in this approach will help ensure that changes can occur on the ground level. The provision of public health services, although it will vary from place to place, needs continuity. There is a disconnect between rural and urban areas, not just in funding areas, but in capacity. He suggested that they define “capacity” in the same manner that they are discussing defining “infrastructure.”

- Dr. Bal said that not only is there no heterogeneity in the field, but also there is no heterogeneity within CDC. The agency has become a bureaucracy. One key function of the workgroup could be to recommend the same commitment to intervention across the agency. This factor affects funding and has been a problem at CDC for some time. He suggested that they create a recommendation for the ACD meeting in April concerning these questions: What do you want? How will you break it down? (e.g., through block funding, formulaic funding, state and local funding). Policy is a significant priority of the CDC Director, and they have not addressed how to accomplish it. The external environment of policy is part of public health’s job. The bureaucracy impedes their progress and interference from HHS, Congress, and even the White House affects policy intervention. Rather than avoiding the issue, he encouraged them to meet the problem head-on, insisting that public health should be proactive. They also have a right to voice their opinions and work as “citizen public health workers.” Given the pressure that CDC is under, he felt that it was unrealistic to expect “political cover” from the agency. Public health vibrancy and leadership must come from the local level. This stridency has eroded in recent years, and it could be due to a loss of leadership, but it also could be in response to “what the people want.” The debate in public health has always centered around individual rights versus community responsibility. If one believes that the community is responsible for the most disadvantaged among them, then there must be strong public health intervention. He shared a list of potential issues and roles for the Workgroup to consider, including the following: block versus categorical, consolidation and inefficiencies, state versus local, current funding, future funding, priorities, Project officers (process perfect / product poor), chronic disease versus communicable disease versus emergency preparedness, CDC role versus state / local role (laboratory function), health insurance (new ball game), PPACA, non-public health functions and partners, and the rich get richer (formula funding versus competitive funding).

- Ms. Gower had provided a list of specific tribal recommendations, which was distributed to the group via email. She commented on the uniqueness of tribal populations which can be difficult for the general population to understand. Issues such as tribal sovereignty, federal trust responsibility, and others influence and affect recommendations for tribal populations. Regarding her participation in the small working group, she felt that she was representing tribal nations and the Indian perspective. She felt the need to represent territorial issues as well, but she was concerned that she did not have adequate knowledge to do that. One of the tribal recommendations focuses on how the STLT community is comprised of four separate entities, each of which needs full representation. She said there should be full

territorial representation, acknowledging that they may have some common issues with tribes. She also appreciated the new tribal position in OSTLTS. They have a different project officer for each of their many grants from CDC, but none of the officers comes with a basic understanding of, or orientation to, tribal nations. She encouraged OSTLTS to ensure that the position was filled by someone who does understand and advocate for tribal positions.

- Dr. Fleming expressed gratitude for the rich discussion and noted that they have a great deal of work ahead. He observed two common themes in their reflections: 1) The public health system, with involvement from states, tribes, locals, territories, and CDC, needs a better way to assess its enterprise and figure out how to do business better; and 2) The public health system is confronting crisis. Many at the state and local levels have been dealing with huge budget pressures, and an unprecedented budget crisis is impending at the federal level. At the same time, there are new resources. He was concerned that, if left to their traditional means for managing crisis, especially at the federal level, the system could become very divided. Because so many people at CDC have spent their careers at CDC as opposed to in the field, when the times comes to identify how to allocate fewer funds, there will be an outside perception of lack of attention and perhaps unfairness regarding how CDC distributes money to the public health system. They must establish a process to prevent that reality and that perception. They need to assess whether CDC leadership is interested in action in the area of combining the urgent crisis of budget reductions with creating a system for looking broadly at the public health jurisdictions in the United States. He asked whether the group felt that they should engage Dr. Frieden to generate a process to enable Dr. Monroe and OSTLTS to have a voice with CDC to help manage budget reductions in a way that does the least harm to the overall public health system. There was general agreement from the group regarding this direction for their efforts. He noted that if they postponed taking on these issues, they may be too late when they do take up the issues. He suggested that they begin by communicating with CDC leadership to determine whether this charge was feasible. They do not want to give advice where it is not needed, and the realities of the federal system may mean that CDC may not want to take on the charge. He asked for ideas from the group regarding how to assist CDC and how to provide input from the STLT community.

- Dr. Fielding agreed that their next priority should be the issues that Dr. Fleming named. He wondered how much of this work comes from CDC alone versus CDC and others, both inside and outside the federal government. Now is the time for CDC to join with both external and internal partners. He was not sure whether it was possible to engage the Secretary of HHS in these issues, and he noted that the Assistant Secretary of HHS, Howard Koh, is an important ally. They are not only trying to prioritize in the face of budget cuts, but they are also establishing the value of core public health so that people know what they are potentially losing. Priorities will differ from place to place, so it is important to give people a sense of what public health is. Everyone has seen significant reductions in recent years. What has been lost as a result of those cuts? They should articulate those losses in a meaningful, logical way to create messaging that resonates at all levels. They can try to reduce the decline through negotiations, hoping to improve the outcome. The STLT community can advocate through its legislators. They can also help shape priorities among core public health. The United States is spending more on health and is getting less. Public health and policy solutions will emphasize the role of public health. Otherwise, every marginal dollar without an appropriation will go into the healthcare system as opposed to public health. There are strong partnerships with the healthcare system that have not been maximized.

- Mr. Auerbach suggested that the STLT Workgroup agree to be flexible in how they address this issue so that they are most useful to OSTLTS. It is beneficial for them to meet in person, so that they can have formal discussion as well as informal talks. They are in difficult political situations and need to think about ways to coordinate their efforts at different levels. In order to be helpful, they must offer their assistance not as a narrowly-defined interest group, but as a group that wants to do what is best for the public health enterprise at large.

- Dr. Farley observed two separate discussions. One is recommendations to CDC regarding priorities after budget cuts, and the other is an advocacy discussion that they cannot have with CDC. Advocacy should happen in another forum. He agreed that their work with CDC should not take the form of advocating for their own agencies.

- Dr. Sanchez mentioned materials that he had from the Texas Association of Local Health Officials. A public health coalition is examining the legislative and characterizing the challenges that the state faces regarding the budget crisis. There may be value in knowing what is being contemplated and having a sense of the challenge that the STLT community will face so that they can shape how to respond to a set of expectations from the White House and / or HHS. It will be helpful to have objective information from the states to learn how they depend on their resources.

- Ms. Selecky said that ASTHO will conduct a budget survey, which will provide important background information. She built on the idea of advocating and meeting with the Assistant Secretary of HHS. She noted that both CDC and the Health Resources and Services Administration (HRSA) fund AIDS work. She wondered whether the two agencies would make different decisions. This is an area for systemic conversations. The Maternal and Child Health (MCH) block grants is influenced by decisions in Immunization, she added. She encouraged conversations concerning the impacts to the STLT community across HHS.

- Dr. Baird said that they could consider other partners that have leverage with Congress. He wondered whether CDC still had a Corporate Round Table. These partners have clout and could carry CDC's message to directional leaders.

Consolidated Chronic Disease Prevention Grant Program

Ursula Bauer, PhD, Director
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Dr. Bauer expressed gratitude for being invited to the meeting. She noted some features of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) budget as reflected in the President's proposed budget released that morning. There has been a cut to NCCDPHP's base of $140 million, which is concerning. They have a budget of approximately $1 billion. That figure is inflated with $650 million in stimulus dollars. Those funds end in March 2012. With the cut to the base came additional dollars from the Prevention and Public Health Fund. Their net budget for 2012 is larger than 2010, not including the stimulus dollars. The new dollars are for new programs, so they will examine the NCCDPHP budget to determine how to manage their resources. They will probably not continue to support all of their programs.

The President's budget collapses about 40 individual budget lines into about five budget lines, Dr. Bauer explained. The lion's share of those lines are collapsed into the "Consolidated Chronic Disease Prevention Grant Program." This line includes the following: Nutrition and Physical Activity, Diabetes Prevention, Heart Disease and Stroke, Cancer, School Health, and Arthritis. Tobacco, Oral Health, Safe Motherhood, Infant Health, and Community Transformation Grants are separate lines. Most of the Prevention and Public Health dollars are allocated to this area. $52 million was appropriated in 2011 to jump-start the State Chronic Disease Prevention Program, and another $157 million in 2012 is allocated to fully flesh the program out. This program is a grant opportunity for state health departments that currently receive a number of categorical chronic disease program grants.

The key feature of the State Chronic Disease Prevention Program is the Center's ability to support chronic disease capacity in state health departments for the first time. They have always funded categorical programs, but they have never supported overall chronic disease prevention capacity. With the $50 million in 2011, and some portion of the $157 million in 2012, NCCDPHP looks to strengthen existing, or build where there are not existing, overarching chronic disease programs in state health departments that can support cross-cutting skills such as surveillance and epidemiology, policy, communications, evaluation, community mobilization, and others. Their categorical programs will be affiliated with, and work under, the State Chronic Disease Program. The categorical programs can focus their dollars on their disease- and risk-factor specific work. She hoped that with enhanced chronic disease capacity, they would be able to foster more coordination and collaboration among those programs. By building cross-cutting skills and resources, the programs will work more efficiently together.

Dr. Bauer noted that four "negotiated agreement" states (Massachusetts, North Carolina, Wisconsin, and Colorado) currently have broad flexibility in how they manage, distribute, and coordinate their categorical chronic disease dollars. The states are halfway through their three-year cooperative agreement. All four states were convened in October 2010 for a reverse site

visit to hear lessons learned, strategies that were used, and details regarding how they reorganized their chronic disease programs to take advantage of the opportunity. The states are doing strong work and are pleased with the flexibility. They have approached the opportunity in different ways, so an immediate lesson is that CDC will not be able to pull a process or structure from the four states to pass on to other states. Different structures and processes work differently in every state, but they can share the lessons learned. A less-positive experience has come from the collaborative chronic disease Funding Opportunity Announcement (FOA), which combined diabetes, tobacco, the Behavioral Risk Factor Surveillance Survey (BRFSS), and Healthy Communities. The grouping was not ideal, and CDC did not provide helpful guidance. This program resulted in one FOA with four discrete sets of activities, and it did not enhance collaboration. NCCDPHP will release an FOA for the $52 million overarching chronic disease program, and they will design a full FOA for the consolidated chronic disease grant program.

Another new grant program, the Community Transformation Grants, is not the traditional cooperative agreement. Communities Putting Prevention to Work (CPPW) is a hybrid. A specific component goes to state health departments, and another component goes to communities, either directly or via a state health department in the case of rural communities. Community Transformation Grants will build on experience with CPPW as well as on experience with a number of different Healthy Communities programs. $145 million is allotted in 2011 for this activity, and the President's Budget provides $221 million. She expressed hope that the fund would continue to grow over time. They expect to scale the Community Transformation Grant program nationally, so they look for increases as the Prevention and Public Health Fund grows over time. The President's Budget offers direction regarding where to make reductions. NCCDPHP will run into difficulty if the Prevention and Public Health Fund does not materialize. The center has a net increase, but a cut to its base. At this point, they are grappling with what the budget looks like and how to design their programming. They hope to address new issues with the consolidated grant. For instance, many states do not have grants for nutrition and physical activity, heart disease and stroke, arthritis, and others. Through the Consolidated Grant Program, they hope to extend that activity to all states.

Discussion Points

- Ms. Selecky asked whether there is a strong rationale for why tobacco is a separate line.

- Dr. Bauer was not aware of a rationale. One might think that tobacco causes heart disease and cancer, so it is related to those diseases. They must group programs somehow, and even though there are different groupings from different entities, NCCDPHP has flexibility in how they operationalize their programs. They are collaborating and coordinating with tobacco.

- Mr. Auerbach requested clarification regarding the Consolidated Chronic Disease Grants, asking whether there would be expectations that each of the six areas would have discrete activities and program goals that would co-exist with efforts to integrate efforts where appropriate.

- Dr. Bauer said that the program will evolve over time, and will launch in 2011 with the establishment of the overarching chronic disease component. The other programs will continue to exist within their current cooperative agreements. Some programs are already bundled together in cooperative agreements. Over time, there would potentially be one FOA to include all programs. They will not necessarily organize the programs along specific disease and risk factor categories, but possibly along functional lines. Instead of building a nutrition and physical activity program, for instance, they might support policy activities to promote nutrition and physical activity. Instead of supporting a separate breast and cervical cancer early detection program, they might fund a set of activities in clinical preventive services to include those kinds of activities. Because all of their activities are linked to Healthy People 2020 goals, performance and outcome measures will relate to the range of chronic disease prevention activities. They will hold themselves and their grantees accountable for reductions in heart disease, stroke, diabetes, et cetera.

- Mr. Auerbach asked whether there would eventually be a single, inclusive consolidated grant, or whether the grants would always be separate and distinct.

- Dr. Bauer replied that transitioning from 40 budget lines to one budget line is a challenge, and starting the effort in 2011 is an even greater challenge. Currently, they are establishing the overarching chronic disease component. In 2012, they will be able to plan how to structure a new program, including whether separate FOAs are needed. A complicated program such as the National Program of Cancer Registries should not be included in a huge FOA, for instance. They are considering how to support the needed activities in a process that makes sense to state health departments. Both Congress and the Executive Branch are moving in the direction of collapsing budget lines, reducing the number of cooperative agreements, and forming a coherent program around the myriad chronic disease activities.

- Ms. Selecky said that her state has been adopting this approach. Four states are going through a pilot of integrated programs, and others are doing their own “look-alikes.” She suggested that those states could offer advice on the process, including stumbling blocks. For instance, her state requires her locals to report as if the programs are still categorical, but also asks them to do broader assessments in their communities. There have been disconnects and frustration as a result.

- Dr. Farley asked whether states would receive guidance regarding how to interact with local health departments. He wondered whether states were free to bypass the LHDs entirely, pass the dollars to community-based organizations, or adopt other approaches.

- Dr. Bauer replied that when grants are awarded to state health departments, there is not generally an expectation that the monies will go to state-based, community-based, or local health organizations. When localities receive grants, they do not necessarily fund district health offices in their jurisdictions. They expect states to implement programs with population-wide impact. Some states may accomplish that goal by providing sub-grants to health departments within their jurisdictions, others may decide to undertake policy initiatives at the state level. Some states do not have local health departments.

- Dr. Bal asked about the procurement and rollout of the Community Transformation Grant.

- Dr. Bauer explained that the Transformation Grant is completely separate from CPPW, although there will be an overlap. They hope to release $145 million this year, and if they are successful, there will be a 6- to 9-month overlap with CPPW, which ends in March 2012. The Transformation Grant is a new procurement and a new application. There is not an expectation that current CPPW grantees will have an advantage in funding.

- Ms. Gower asked whether tribal governments are eligible for these grants. Dr. Bauer replied that they are.

- Dr. Fleming asked about the $140 million reduction in NCCDPHP's base and whether the center has created a process for determining how to make that reduction.

- Dr. Bauer answered that NCCDPHP has budget lines that do not appear in the President's Budget; therefore, the President does not expect to see those activities continue. In some cases, when an existing line has no funding in 2012, as with the Racial and Ethnic Approaches to Community Health (REACH) program, language says that the activity should be included in the Community Transformation Grants. Current grantees under REACH will not be funded under the Community Transformation Grants; rather, the kinds of activities supported under REACH will be supported under the Community Transformation Grants. The statutory language around the Community Transformation Grants directs CDC to use the funds to achieve reductions in health disparities as well as population-wide change. Other programs are not included in the President's Budget, such as inflammatory bowel and psoriasis programs. In areas such as these, the public health message and public interventions were not clear. Perhaps the programs were not a good fit, so those programs will not be prioritized in the new, smaller core budget.

- Dr. Bal asked whether the Community Transformation Grants focus only on the states, or on states and locals.

- Dr. Bauer answered that they focus on both state and local entities. The statute stipulates that eligible entities include state and local governments, state and local non-governmental organizations, and tribal organizations. The duration depends on how long the Prevention and Public Health Fund lasts. NCCDPHP envisions a new five-year cooperative agreement for eligible grantees.

- Dr. Fielding asked how NCCDPHP will promote the new grants that are available to states, localities, and others, when there will likely be competition within a geographic area.

- Dr. Bauer replied that the FOA is in the clearance process through HHS and OMB. It builds on the approach of Communities Putting Prevention to Work, in which communities needed to assemble a multi-sectorial team with many partners in order to achieve and implement policy change. They hope not to see competition within a jurisdiction; rather, the hope that grantees will work together to determine the best agency to apply for the grant and the best members to tap for the coalition. CDC cannot prohibit competition, so there may be competition, but they expect to see multiple sectors and many organizations working together on the applications.

- Ms. Selecky asked whether a private, non-profit entity applying for the grant was compelled to reach out to the state and local health department. Even if the groups have a good relationship, they might opt to compete for a strong grant opportunity.

- Dr. Bauer answered that the FOA has not been cleared, so she was not sure of its final iteration. They do, however, often require a letter of intent. They hope to ask every applicant to file a letter of intent and that applicants give permission to post that information. There will be a website that those interested in the funding opportunity can consult to learn who has submitted letters of intent and contact those entities to work together.

- Dr. Fleming said that the workgroup has been tasked with providing OSTLTS and CDC with useful advice. He asked Dr. Bauer if there were areas in which she felt she could use advice from states, locals, territories, and tribes. There is a strong Chronic Disease Director program already, but he wondered about additional areas for consultation.

- Dr. Bauer offered two areas in which the group could be helpful. First, as NCCDPHP thinks through the development of the large, consolidated chronic disease grant program, they would appreciate input on what the program will look like and how state health departments will be able to make the program work for them. State health departments and NCCDPHP may not currently have the expertise, skills, and staff to get where they envision themselves in five years. NCCDPHP looks forward to the expertise that it needs to ensure the STLT helps them form that vision and make changes over time. Another area in which advice would be welcomed concerns the project officer program. They are reorganizing how they train, manage, and support project officers so they can deliver better services to grantees. This challenge has been on-going across CDC. It was addressed in the past by the Project Officer of the Future program, which has worked well, but the program has been small. They have not been able to retrain the existing cadre of project officers through that program. They plan to continue to locate the project officers within the programs they serve. Further, they plan to provide oversight training, orientation, and skill-building more centrally. It would be helpful to identify the needs and gaps in the system.

- Dr. Bal noted that many people do not understand what public health aims to achieve, noting that every level, from the federal to the local, has its own problems and priorities. He asked about CDC's plans to get where it wants to be, given this confusion.

- Dr. Bauer replied that the agency has thought about how they message about their work. NCCDPHP focuses on demonstrating demand. The "nanny state" is a phrase on many lips, and there is a perception of an overbearing, paternalistic government that tells people what to do. She did not believe this was the case. The reason there are smoke-free laws and

nutrition policies is because the people demand these efforts. They need to message the demand and benefit more clearly so the government can deliver what the people ask for.

- Dr. Farley said that the group had discussed project officers earlier in the day. As they are consolidating across several grants, he wondered whether they were considering collapsing the number of project officers as a result and if system-wide lessons could be learned.

- Dr. Bauer said that NCCDPHP was in the initial stages of thinking about the project officer system, and she welcomed input into the issue. One source of frustration is trying to get project officers to work together across programs. Every program "carves up" the country in a different way, making that collaboration difficult. Each project officer has a different group of states with which they work, so each officer belongs to different teams, which does not make sense. If all programs carved up the country in the same way, then teams of project officers could be built and they could cross-message and complement each other's activity. They are also considering instituting a "Lead Project Officer" for each state. The individual, potentially a higher grade than most project officers, could act as the team lead and the "go-to" person for the grantees. They are considering these two approaches and whether they would result in fewer project officers and clear lines of responsibility.

- Dr. Sanchez told Dr. Bauer that the workgroup discussed the idea of a lead project officer. They also discussed the notion of project manager as a function, rather than a person. They had discussed whether all the necessary functionality and capacity was comprised in the team, or readily available. Expertise in health, procurement and contracts, policy and legal areas, and even evaluation may not all be found in one individual, but in teams that bring subject matter expertise in these, and other, functionalities.

- Dr. Bauer said that the subject matter expertise could come from outside the project officer cohort. Project officers cannot be expected to be experts in all of the areas, but their expertise needs to be developed in cross-cutting areas as they are empowered to refer grantees to subject matter experts at CDC and elsewhere when needed.

- Ms. Gower spoke as one of the representatives for tribal governments in the workgroup. As they think about dividing up the country, she suggested that they consider a specific tribal recommendation, which includes specific training for project officers in tribal sovereignty, federal trust responsibility, and government-to-government relationships with tribal nations. Perhaps all officers could receive that orientation, or a set of project officers could focus just on tribal governments. Dr. Bauer liked the latter idea.

- Dr. Fielding reiterated that the CPPW funds end in March 2012; however, all grantees will not have spent all of their money by then. He asked about efforts to recapture that money.

- Dr. Bauer had not heard of any such efforts, but not hearing about efforts does not mean that the money will not be recaptured. They have monitored CPPW expenditures closely. They got off to a slow start, and they are catching up, but it is likely that dollars will be left over. She has heard discussions of no-cost extensions, as two years was a short timeframe. She warned grantees not to rely on that extension, however.

- Dr. Fielding asked about the approach to technical assistance in the CPPW grants, in which all experts were convened at the first meeting. He wondered how well the experts had been utilized and whether the model had worked well.

- Dr. Bauer replied that CDC does not always have the expertise or the staff to provide expertise to a range of grantees. For this reason, reaching out to national organizations with the appropriate expertise who can focus on specific areas so that grantees can link to them for needed technical assistance is the only way to do business in a grant program of that size. With Community Transformation Grants, they are considering a similar model. National support for CPPW was housed in HHS, but there were communication issues and vision differences. Technical assistance will be better coordinated in-house.

- Mr. Auerbach shared his experience from one of the integrated chronic disease states. He said it is different to transform the way that people think about working in the consolidated chronic disease approach. They have built “silos” and trained people to work within them and to defend them. People’s initial instincts are still to protect the things with which they are comfortable. The more flexibility that exists in working across areas, the better. While the integrated approach has allowed for more flexibility, some rules prohibit some flexibility, such as reallocating dollars, sharing expenses across too many grants, or getting all of the project officers “on the same page” about making changes.

- Dr. Bauer said that the problem of the ability to share resources across programs is eliminated by the fact that there are not separate lines for each program—there is just one line. Individual programmatic integrity is preserved by performance and outcome measures for which grantees are held accountable. The grantee will decide how to allocate resources in the cooperative agreement to best achieve those outcomes. NCCDPHP’s challenge will be how to support the work through project officers and disease- and risk-factor-specific Divisions. One of the reasons the collaborative FOA that she mentioned before was not successful was that NCCDPHP did not model the behavior they were asking grantees to adopt, she said. At this time, NCCDPHP is considering a reorganization to deliver programs better. The four integrated states have commented that this is a different way of working and thinking, and it is a process.

- Dr. Rivera gave her thanks for the CPPW grant in Miami, Florida, which is showing great accomplishments at the local level. She asked about whether policy and environmental changes were being monitored across the nation.

- Dr. Bauer answered that they are frequently asked for successes and impacts achieved by the community grantees. They have a one-year retrospective catalog of work, with an impressive list of policies that have been advanced during the grant period. The multi-sectorial teams have come together well, she said, and they have high hopes for achievements in the second year.

- Dr. Farley asked whether the policy successes were helping or hurting them.

- Dr. Bauer replied that because they committed to policy changes, they have been able to say that changes were accomplished. Whether the efforts hurt the initiative in the long run depends on how they message what they were able to deliver to the people because the people demanded it.

- Dr. Bal commented that much of the CPPW media messaging from CDC was out of sync. If policy change is successful, then it will "spook" Washington. He implored them to stay the course if the program is working.

- Dr. Bauer asked how she might stay in touch with the workgroup in order to ask for more insights as the Center's changes are considered.

- Dr. Monroe said that they would convene calls, and Dr. Farley added that they hoped to be available for rapid response when needed.

Wrap-Up and Adjourn

David Fleming, MD
Director and Health Officer, Public Health – Seattle and King County
Chair, State, Tribal, Local and Territorial Workgroup of the Advisory Committee to the Director

Judy Monroe, MD
Deputy Director, Centers for Disease Control and Prevention
Director, Office for State, Tribal, Local and Territorial Support

Dr. Fleming asked if they could see a high-level summary of the President's Budget. He then asked for additional comments regarding the workgroup's next directions as well as feedback regarding what worked and what did not work in the day's meeting.

Discussion Points

- Ms. Selecky wondered how many other areas of CDC were considering changes in the project officer system. Further, she wondered about the choice to maintain separate officers and to add a senior officer. They seem to have a supreme opportunity to make innovative changes in the system.
- Dr. Monroe answered that these changes are building upon past work in NCCDPHP with the Project Officer of the Future. Ms. Loy commented that HIV may be making similar changes to the project officer system.

- Dr. Fielding said that many different programs will be consolidated into, in essence, a block grant for chronic disease prevention while significantly reducing funding. He hoped that they would keep their expectations reasonable. The new grants bring more funds, but the base is being reduced, he reminded them. Additionally, he felt that they should support keeping the Prevention and Public Health Fund intact. He predicted that the fund would be a target, and they need to unite to support it.

- Mr. Auerbach added that it will be difficult for the workgroup to have a role in thinking about how decision-making is made in response to shrinking budgets. At CDC, people are thinking about how to make cuts and how to backfill and shift funds. It may not be realistic for the workgroup to think that they can have a significant impact if things are moving quickly, and in disparate ways, across the different centers at CDC.

- Dr. Monroe agreed that CDC is a decentralized agency, and things are moving quickly. She would meet with Dr. Frieden at the end of the week to learn his thoughts on this topic.

- Dr. Farley said that the NCCDPHP grant probably should have been combined some time ago, and he was glad to hear that NCCDPHP was reorganizing to match the grant. As other grants are being combined, other centers will face the same issue. He felt that they should encourage CDC and states to reorganize around this effort, otherwise they will not operate efficiently.

- In thinking about reorganizing, Dr. Monroe asked for feedback regarding the role of performance managers and whether they may provide extra capacity at the state level: 49 states, 10 large cities, and 8 tribes accepted funds through the ACA to hire performance managers to think about cross-cutting issues across their agencies.

- Dr. Sanchez said that in reorganizing and consolidating, they should consider the expectations of the grants. He recalled feeling frustrated when health department dollars were being spent on cardiovascular disease and stroke, which are medical care delivery system issues. He wondered whether there is a more logical way to think about differences in the ACA environment that obviates the need for some programs and focuses more on how to bring public health and medical care delivery together, rather than to support clinical practice. In terms of performance management, there is value in determining priorities and where to invest dollars. Further, when things are moving fast, OSTLTS may help the workgroup determine areas in which they can help and make a difference.

- Dr. Fleming noted on the President's Budget that the Preventive Health and Health Services block grant was eliminated. There is a $580 million reduction in CDC's budget. Public health leadership and support is being reduced. The group examined the budget together, noting changes.

- Dr. Bal emphasized that chronic disease has been underfunded; however, it is easy to show the burden of disease. He wondered whether CDC would have any discretion in reconciling the budget cuts between the House and President's budgets.

- Dr. Monroe said that epidemiologic capacity is important to CDC, and chronic disease is important as well. Beyond that, she was not certain where the cuts and priorities fall.

- Dr. Farley asked about potential for changing this budget.

- Ms. Selecky said that the processes are very different this year. In previous years, the Prevention Block Grants have been zeroed out. Coalitions of health groups have advocated for its reinstatement. This year is different. Any alignments between the President's Budget and the House's Budget are likely to remain the same.

- Dr. Fleming said that Dr. Monroe and Dr. Frieden would assess where the workgroup has the best opportunities to be of assistance.

- Dr. Bal asked about the process between then and the April 2011 ACD meeting.

- Dr. Fleming answered that the small working group would synthesize the larger group's feedback on the recommendations. This document will be circulated to the group and presented for additional comments and input. They will have an opportunity to present the recommendations to ACD, whether they are a final product, or whether additional vetting within CDC is needed.

- Dr. Sanchez said that if they intend to bring a recommendation to the ACD in April, they should do so quickly in order to refine language and expectations so the recommendations make sense for CDC.

- Dr. Fleming asked for feedback about the general structure of the meeting, or for other thoughts beyond the agenda.

- Ms. Loy said that they would convene a phone call when the group had time to digest the President's Budget. Dr. Fleming said that after the discussions with Dr. Frieden, they could set an agenda for the call and schedule it for when they can convene the most people.

- Ms. Selecky recommended that OSTLTS connect with Preparedness. The preparedness grants have built a systemic infrastructure process over the last nine years, and the reduction in that area was $72 million. OSTLTS could think about systems more broadly.

- Dr. Monroe answered that the cut in preparedness did not come as a surprise. She noted that OSTLTS has good connections with Preparedness.

- Ms. Selecky hoped that they would look more comprehensively, beyond preparedness to include how the business of public health is done.

- Dr. Fleming expressed his gratification at the group's willingness to devote their time to the group. He asked for thoughts regarding how to improve the group's productivity.

- Dr. Farley felt that the process had worked well, and he applauded the approach of creating a smaller group to create recommendations to act as a springboard for discussion.

- Dr. Sanchez said that OSTLTS should ask itself whether the process had been productive for them, for CDC, and for Dr. Frieden.

With that, Dr. Fleming and Dr. Monroe thanked the group for their rich discussion and the meeting was officially adjourned at 3:15 PM.

Attendee Roster

Insert attendee roster here

Appendix A

Insert "road map" here