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OFFICE OF MINORITY HEALTH AND  
HEALTH Equity

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## HEALTH DISPARITIES SUBCOMMITTEE

+ + + + +

THURSDAY  
FEBRUARY 2, 2017

+ + + + +

The Subcommittee met by  
teleconference at 1:30 p.m., Lynne Richardson,  
Chair, presiding.

PRESENT

LYNNE D. RICHARDSON, M.D., Chair

ANTHONY ITON, M.D., J.D., M.P.H., Senior Vice  
President, Health Communities, The California  
EndowmentDAVID FUKUZAWA, M.Div, M.S.A, Program Director  
for Health, The Kresge FoundationMARY GARZA, Ph.D, M.P.H, Assistant Professor,  
University of Maryland School of Public HealthGARTH GRAHAM, M.D., M.P.H., President, Aetna  
FoundationMARGUERITE RO, Dr.P.H., Chief, Assessment, Policy  
Development, and Evaluation Section, Public  
Health, Seattle-King CountyWILL ROSS, M.D., M.P.H., Associate Dean for  
Diversity, Washington University School of  
MedicineHECTOR VARGAS, Executive Director, Gay and  
Lesbian Medical Association, Health  
Professionals Advancing LGBT Equality**NEAL R. GROSS**COURT REPORTERS AND TRANSCRIBERS  
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CHERI WILSON, M.A., M.H.S., CPHQ, Director,  
Diversity and Inclusion, Robert Wood Johnson  
University Hospital

WILMA WOOTEN, M.D., M.P.H., Public Health  
Officer, County of San Diego Health and Human  
Services Agency

ALSO PRESENT

MELANIE DUCKWORTH, Ph.D, Senior Advisor to the  
Director, Office of Minority Health and Health  
Equity

JEFFREY HALL, Ph.D, MSPH, CPH, Behavioral  
Scientist, Etiology and Surveillance Branch,  
Division of Violence Prevention, National  
Center for Injury Prevention and Control

DAVID HUANG, NCHS, Ph.D., M.P.H., C.P.H., Office  
of Analysis

LEANDRIS LIBURD, Ph.D., M.P.H., Designated  
Federal Officer

ANA PENMAN-AGUILAR, Ph.D., Associate Director for  
Science, Office of Minority Health and Health  
Equity

JUDY RICHARDS

ANNE SCHUCHAT, M.D., Acting Director CDC/ATSDR

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1 P-R-O-C-E-E-D-I-N-G-S

2 1:31 p.m.

3 DR. LIBURD: So good afternoon,  
4 everyone. This is Leandris Liburd. I am the  
5 Designated Federal Officer for the Health  
6 Disparities Subcommittee, and I will go ahead and  
7 start our meeting with the official roll call.  
8 Please indicate if you are present when I call  
9 your name. Lynne Richardson?

10 CHAIR RICHARDSON: I am present.

11 DR. LIBURD: David Fukuzawa?

12 MR. FUKUZAWA: Present.

13 DR. LIBURD: Mary Garza?

14 (No audible response.)

15 DR. LIBURD: Garth Graham?

16 DR. GRAHAM: Present.

17 DR. LIBURD: LaMar Hasbrouck?

18 (No audible response.)

19 DR. LIBURD: Willie Horner Johnson?

20 (No audible response.)

21 DR. LIBURD: Anthony Iton?

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1 (No audible response.)  
2 DR. LIBURD: Maureen Lichtveld?  
3 (No audible response.)  
4 DR. LIBURD: Marguerite Ro?  
5 MS. RO: Present.  
6 DR. LIBURD: Will Ross?  
7 MR. ROSS: Present.  
8 DR. LIBURD: Mildred Constance?  
9 (No audible response.)  
10 DR. LIBURD: Hector Vargas?  
11 MR. VARGAS: Present.  
12 DR. LIBURD: Donald Warne? Don?  
13 (No audible response.)  
14 CHAIR RICHARDSON: He might be muted.  
15 DR. LIBURD: Okay. Are you on mute?  
16 (No audible response.)  
17 DR. LIBURD: Okay. We know he is  
18 here.  
19 PARTICIPANT: Yes, I thought I heard  
20 him come on earlier.  
21 DR. LIBURD: Yes, he did. Cheri

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1 Wilson?

2 MS. WILSON: Here.

3 DR. LIBURD: Wilma Wooten?

4 MS. WOOTEN: Here.

5 DR. LIBURD: I am going to go back  
6 and double-check that Mary Garza --

7 MS. GARZA: Here.

8 DR. LIBURD: LaMar Hasbrouck?

9 (No audible response.)

10 DR. LIBURD: Willie Horner Johnson?

11 (No audible response.)

12 DR. LIBURD: Anthony Iton?

13 MR. ITON: I am here.

14 DR. LIBURD: Okay. Great. So --

15 CHAIR RICHARDSON: Would you read for  
16 us Leandris who you have as present?

17 DR. LIBURD: Yes. So I have Lynne  
18 Richardson, David Fukuzawa, Mary Garza, Garth  
19 Graham, Anthony Iton, Marguerite Ro, Will Ross,  
20 Hector Vargas, Don Warne, Cheri Wilson, and Wilma  
21 Wooten.

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1 CHAIR RICHARDSON: Are there any HDS  
2 members whose name Leandris did not just call who  
3 are on the line?

4 (No audible response.)

5 DR. LIBURD: So we -- we have a  
6 quorum, and we can begin the meeting, and if any  
7 Health Disparities Subcommittee members join,  
8 please let us know at a different point on the  
9 agenda.

10 CHAIR RICHARDSON: Okay, Leandris.  
11 Could we just give an opportunity for any CDC  
12 staff or members of the public who are on to  
13 identify themselves?

14 DR. LIBURD: Yes. So we can start in  
15 this room. This is Leandris Liburd, and I am  
16 here with Melanie Duckworth. So who is on the  
17 phone?

18 MR. HALL: This is Jeff Hall.

19 MS. RICHARDS: Judy Richards here.  
20 Oh, sorry.

21 DR. LIBURD: Okay. Dr. Anne Schuchat

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1 has just joined.

2 DR. SCHUCHAT: Good morning.

3 DR. HUANG: Hi. This is David Huang  
4 from NCHS.

5 DR. LIBURD: David, great, good  
6 morning -- I mean afternoon. Anyone else?

7 (No audible response.)

8 DR. LIBURD: Okay. Great.

9 CHAIR RICHARDSON: Okay. Thank you,  
10 Leandris.

11 So I -- I did hear that Anne Schuchat  
12 is on the phone, so to be respectful of what I  
13 can only imagine is her very busy schedule, I  
14 think we're going to move right to an update on  
15 the transition from Anne, and thank you so much  
16 for joining us.

17 DR. SCHUCHAT: Well, thanks so much  
18 for inviting me, and thank you for all that you  
19 do. I was really pleased to get to meet with the  
20 subcommittee last year when you were in town for  
21 the last meeting in my role as Principal Deputy

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1 Director, and I am pleased to get to join you by  
2 phone today in my new role.

3 I wanted to share with you some of the  
4 internal changes that reflect our temporary --  
5 you know, our transition status. In addition to  
6 my serving as the Acting Director for CDC, Pattie  
7 Simone has joined us as the Acting Principal  
8 Deputy Director. I think many of you will know  
9 Pattie from her work leading the division that  
10 is focused on training and workforce and her  
11 prior work as Principal Deputy Director for our  
12 Global Health Group, so she brings a huge amount  
13 of experience to our leadership team here.

14 And then also I'll let you know that  
15 Sarah Wiley has joined as the Acting Chief of  
16 Staff for CDC. She is usually the Senior Advisor  
17 in the Office of Infectious Diseases here, and  
18 those of you on the Advisory Committee to the  
19 Director will probably remember Sarah, as she  
20 served as the Designated Federal Official for the  
21 Laboratory Safety Working Group to the Advisory

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1 Committee to the Director, so Sarah will be  
2 Acting Chief of Staff and also in that role  
3 serving as the Designated Federal Official to the  
4 whole Advisory Committee to the Director.

5 You know, the team -- the others that  
6 you were familiar with remain in place, with  
7 Katherine Lyon Daniel as the Lead for  
8 Communication and Sherri Berger as our Chief  
9 Operating Officer. Karyn Richman is now the  
10 Acting Director for our CDC Washington office,  
11 and Von Nguyen is leading the Office of the  
12 Associate Director for Policy, as John Auerbach  
13 moved on to the Trust for America's Health, so  
14 it's a great team, and we are all interim except  
15 for the people who were here before us, but we're  
16 very pleased to get to work with our advisory  
17 committees and subcommittees on the Agency's key  
18 work.

19 You know, from my perspective, there  
20 is a lot of really good work that the Agency has  
21 been doing recently on health disparities and

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1 equity issues. I hope you saw the January Vital  
2 Signs that was focusing on improvements in  
3 chronic renal disease among diabetics who are  
4 American Indian or Alaska native. We have had  
5 actually great progress in the chronic renal  
6 disease sequelae among people with diabetes in  
7 the tribal communities, and so that was actually  
8 a good news story about using best practices and  
9 models that could be used in other areas.

10 We also had a recent MMWR really  
11 highlighting rural health and some of the really  
12 shocking disparities that were seen in rural  
13 areas around the country. That was a  
14 surveillance summary in the January -- in January  
15 for the MMWR, but it was launching a yearlong set  
16 of articles about rural health issues, and so  
17 that -- one of the equity issues that we really  
18 want to be highlighting right now is we have  
19 uncovered pretty exceptionally high rates of  
20 mortality in rural populations.

21 Next month, we're going to be --

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1       actually, this month, wait a minute, February,  
2       we're going to be highlighting hearing loss as a  
3       major health problem that hasn't gotten that much  
4       attention, and that has been a partnership across  
5       multiple centers here, but again one where there  
6       are some important disparities that we will be  
7       signaling.     So I think the scientific and  
8       programmatic work is continuing, and with high  
9       visibility - that is, as highly visible as we can  
10      have.

11               In terms of the information about the  
12      transition, I would say that before a Secretary  
13      is appointed for HHS, we are pretty much in a  
14      holding pattern.   I have had several meetings  
15      with first the transition team, and now with the  
16      incoming -- a small number of staff at the  
17      Department of Health and Human Services, but they  
18      are really focused on organizationally getting  
19      set up and looking -- I would say their priority  
20      right now is really looking at regulations that  
21      are recently released and not yet implemented or

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1       about to be released so that they can take a look  
2       at those. So we don't have a whole lot of  
3       direction yet about priorities other than what  
4       you can see in the media in terms of the issues  
5       related to health reform.

6               My position as Acting Director is, you  
7       know, personally an incredible privilege, and  
8       since I have been at CDC for 29 years, it is  
9       really kind of exciting to get to do this and  
10      represent the Agency and mainly, support the good  
11      work going on here, but I don't have information  
12      about how long I will be in this role. The key  
13      message for you all is that the folks you have  
14      been working with are still here, and we are  
15      still committed to work closely with you and get  
16      the advice that you have.

17             I wish I knew more, but what I promise  
18      to folks inside the Agency and also want to share  
19      with partners and advisors is that as I know  
20      more, I hope to be able to update people as fully  
21      as I can, so that is kind of my -- what I can

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1 tell you, but I am happy to try to answer  
2 questions if you have any.

3 CHAIR RICHARDSON: Thank you so much  
4 for that, Anne. Are there any questions from  
5 any members of the committee?

6 MR. ROSS: This is Will Ross. Dr.  
7 Schuchat, thank you. We are privileged to have  
8 you here, even in an acting capacity, so thank  
9 you.

10 So in terms of the briefing, the Trump  
11 administration, do you have to wait until the  
12 Secretary is confirmed, or have you had  
13 opportunities to do so beforehand?

14 DR. SCHUCHAT: We -- we have been able  
15 to do the high-level what is CDC, and they had  
16 requested some -- the transition team had  
17 requested some particular briefings on public  
18 health emergencies and how we had dealt with them  
19 in the past, for instance Ebola and the pandemic,  
20 and there was a separate briefing on Zika so they  
21 would know what the situation was and what to

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1 expect, so that was with the transition team  
2 prior to the inauguration.

3 Since the inauguration, there is  
4 something called a beachhead team that is set up  
5 at Health and Human Services, some individuals  
6 who are going through a Senate confirmation type  
7 process, and they are really in the catcher's  
8 mitt mode right now of just trying to learn what  
9 are the actions of the week that they need to  
10 know about, and so I have had a couple video  
11 conferences with them, but it's not yet at the  
12 point of setting priorities or direction.

13 MR. ROSS: Okay. Thanks.

14 MS. RO: Hi. This is Marguerite Ro,  
15 and Dr. Schuchat, again, thank you for taking the  
16 time out of your day to join us.

17 So we are hearing a lot I think in the  
18 media about the potential for the repeal of the  
19 ACA, and I am just wondering whether or not --  
20 because I don't recall whether or not the CDC  
21 Office of Minority Health and Health Equity was

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1 created under the ACA or whether or not we had  
2 that prior to the ACA, and just wondering about  
3 what potential impact on funding for the office?

4 DR. SCHUCHAT: I believe that our  
5 office predated the Affordable Care Act. Our  
6 positions were there before that. The funding  
7 for the office activities doesn't come through  
8 the Affordable Care Act funding. Our Agency does  
9 get funds that are called the Prevention and  
10 Public Health Fund which actually account for  
11 more than 10 percent, I believe it's 12 percent,  
12 of our Agency's budget.

13 The Prevention and Public Health Fund  
14 was part of the Affordable Care Act, and so there  
15 has been some concern that appeal of the  
16 Affordable Care Act would impact that fund. The  
17 funds are actually used for core or base  
18 activities and are not related to health reform,  
19 and so that we've been able to signal that for  
20 instance to the transition team that funding is  
21 separate from exchanges and so forth.

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1                   But the budget horizon really remains  
2           to be seen.    I think that in terms of the  
3           executive orders that have already been publicly  
4           made, I think we all really need to be ready for  
5           some budget uncertainty and some challenging  
6           federal budget times, but I don't have specific  
7           information about that.   In terms of the office  
8           setup, though, we believe that predated the  
9           health reform bill.

10                   DR. RO:   Thank you.

11                   CHAIR RICHARDSON:   Other questions?

12                   (No audible response.)

13                   CHAIR RICHARDSON:   Really?   I am very  
14           surprised at this group, although I think we all  
15           appreciate that, as you say, we all have to be  
16           prepared for a certain level of uncertainty in a  
17           number of arenas.

18                   With respect to at least the -- sort  
19           of the immediate workings of this committee, do  
20           you anticipate that we will meet as usual in the  
21           spring in CDC, that all of that is sort of on

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1       automatic pilot until there is a change, or is  
2       it in limbo until there is clear direction?

3               DR. SCHUCHAT:     Thanks for raising  
4       that. I had meant to include that in my remarks.  
5       We will be sending a communication out to the  
6       Advisory Committee to the Director members soon.  
7       We were able to speak with the chair, David  
8       Fleming, yesterday to talk a little bit about  
9       that.

10              I think the thinking is we have great  
11       members of the ACD and very busy schedules, and  
12       everybody has held that date in April for the  
13       next meeting, so we didn't really want to release  
14       it right now. In the back of our minds, though,  
15       there was the idea that perhaps if we know that  
16       we will have a new Director in place, you know,  
17       for instance by May, it might be nice to delay  
18       the meeting a little bit so that the committee  
19       could meet with the new Director. When will we  
20       know that? Who knows?

21              So what we have decided is to keep the

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1 April date for now, to poll people about possible  
2 dates in May, but for the time being really plan  
3 to go ahead so that we can benefit from their  
4 advice. The thinking is that a new Director  
5 would benefit from meeting with the advisory  
6 committee and vice versa, but if we have an  
7 extended period of interim leadership, it would  
8 be a great time to hear their perspectives. So  
9 I think the meeting planned for April, for now,  
10 we're planning to go ahead with it, but it will  
11 be a little bit clearer in the message that we  
12 send out soon.

13 CHAIR RICHARDSON: Okay. So stay  
14 tuned, but at this point, we should all leave  
15 those dates on our calendars, okay.

16 I did hear someone else join. Did a  
17 member of the Health Disparities Subcommittee  
18 just call in?

19 (No audible response.)

20 CHAIR RICHARDSON: Okay. Perhaps it  
21 was someone else. Any other questions for Dr.

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1 Schuchat?

2 (No audible response.)

3 CHAIR RICHARDSON: Well then, again,  
4 I would like to thank you. We are very  
5 appreciative that you did take the time to join  
6 us telephonically. We really do appreciate that  
7 and do take your participation today as a sign  
8 of the importance that the work of this  
9 subcommittee holds for you, and we are very  
10 appreciative of that support, and we look forward  
11 to doing whatever we can to support you in your  
12 role as Acting Director and then as we all move  
13 forward into this brave new world.

14 DR. SCHUCHAT: Well, let me just  
15 thank you, Lynne, and thank the whole  
16 subcommittee. I really appreciate what you do  
17 outside and what you do for us on the  
18 subcommittee. You know, we get really good  
19 advice from our advisory group, and it helps us  
20 make sure we are on track, so thanks for the time  
21 that everybody is putting into this, and

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1       Leandris, thank you for your leadership of the  
2       group.

3                   CHAIR RICHARDSON:     Absolutely.     I  
4       would like to second that shout-out to Leandris.

5                   Okay.     Well, with that, I guess we  
6       will release you to go on with what I am sure is  
7       a very busy day, and we will move on with our  
8       agenda.     So I don't have too much in the way of  
9       opening remarks, and Leandris, is your update on  
10      here anywhere, or is it --

11                   DR. LIBURD:     Yes, it is, and I do have  
12      one thing I wanted to share with the subcommittee  
13      in terms of an update, which is that we are in  
14      the throes of planning our third annual Public  
15      Health Ethics Forum in collaboration with  
16      Tuskegee University.     This year, we are going to  
17      do it in May.     It will be May the 19th, and the  
18      theme will be around women's health and women's  
19      health across the life cycle, and so, stay tuned.  
20      We will be sharing more.     It will be here in  
21      Atlanta at the Global Communications Center.

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1           One of the things I want to just  
2       raise, put on the radar for our academic  
3       colleagues is that we will be reaching out to  
4       academic institutions this time I think in a more  
5       targeted way, a more concerted way, to encourage  
6       students to participate virtually. We are  
7       hopeful that faculty will support their  
8       participation by maybe providing some academic  
9       credit, having them do some follow-up assignment  
10      based on presentations or panels or some of the  
11      information that will be coming forward through  
12      the forum.

13           So that is my primary update for  
14      today, and you will be hearing more from us about  
15      this. And --

16           (Simultaneous speaking.)

17           DR. ROSS: Hi --

18           DR. LIBURD: -- any questions --

19           DR. ROSS: -- Leandris, this is Will.

20           DR. LIBURD: Yes.

21           DR. ROSS:     Regarding prospective

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1 members for HDS, I know you had asked for our  
2 input. I submitted some names. What is the time  
3 period for actually identifying and having HDS  
4 members brought on board? I presume we are  
5 talking after May sometime, right?

6 DR. LIBURD: Right. Yes, we are  
7 getting names and resumes right now along with a  
8 letter of recommendation that also comes with the  
9 nomination, and we will be making a decision  
10 let's say in May because the members who are  
11 rotating off and those whom we cannot extend,  
12 their term ends on June 30<sup>th</sup>. To give us time to  
13 go through all of the processes of onboarding  
14 subcommittee members, we are accepting their  
15 information and nominations now, and hope to have  
16 people committed by the end of May.

17 CHAIR RICHARDSON: I would like to  
18 point out, and correct me if I am wrong, Leandris,  
19 that current members, even if their terms are due  
20 to end in June, continue to serve until their  
21 successors are duly appointed and approved. Is

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1       that correct, Leandris? I think they went over  
2       that at an ACD meeting.

3               DR. LIBURD: Okay. Yes, I know --

4               CHAIR RICHARDSON: I just don't want  
5       people to think they are going to be allowed to  
6       disappear June 30th if we have not yet gotten the  
7       new members processed, which I assume may have  
8       to await a new Director. I don't know. I don't  
9       know if that is something that can happen during  
10      the transition.

11              DR. ROSS: My daughter is trying to  
12      make me hip, and they said the new word is ghost  
13      rather than disappear.

14              (Laughter.)

15              CHAIR RICHARDSON: I see. Thank you  
16      for that.

17              DR. ROSS: Sure.

18              DR. LIBURD: Okay. I can certainly  
19      confirm that. I think members can be extended  
20      for up to 180 days with approval.

21              CHAIR RICHARDSON: Well, I thought

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1       that they continued until their successor was  
2       confirmed, but there was a limit to how long that  
3       could happen. Perhaps it's a year. I don't know  
4       if everyone actually knows when their term is  
5       expiring or who would be rotating off come June,  
6       but I would hate to lose momentum because we lose  
7       a significant number of our current members and  
8       for whatever reason the new members are not yet  
9       processed and approved and appointed.

10               DR. ROSS: Lynne, that was my point  
11       also. I just was concerned we were going to lose  
12       something in the transition.

13               CHAIR RICHARDSON: Yes, so --

14               DR. ROSS: Take a look at that.

15               CHAIR RICHARDSON: Yes, we will look  
16       into the legalities of that and get back to you  
17       so that people can sort of know what to expect  
18       in terms of whether their service might be  
19       continuing past June 30th. I think it would be  
20       extraordinarily ambitious to believe that we  
21       would have everyone confirmed and appointed by

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1 June 30th, although perhaps it would be possible  
2 before we met in the fall.

3 DR. LIBURD: Yes, and I can certainly  
4 let everyone know their term. We're in the  
5 process now of extending several members for  
6 another two years. They are aware that they are  
7 being extended.

8 CHAIR RICHARDSON: Reappointed?  
9 Yes.

10 DR. LIBURD: Yes, and then we can let  
11 the members know. Some members have served three  
12 terms, and we can't extend them any more.

13 CHAIR RICHARDSON: Right.

14 DR. LIBURD: We'll let those members  
15 know as well, and I have actually spoken with a  
16 couple of members about their interest in  
17 continuing because yes, I do think the  
18 consistency is important. I think that this has  
19 been an incredibly productive subcommittee, and  
20 we certainly don't want to lose any of our  
21 momentum.

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1                   CHAIR     RICHARDSON:           Absolutely.  
2     Okay.    So thank you for that, Leandris.    So I  
3     don't really have much in the way of opening  
4     remarks.    I think this is a particularly  
5     challenging time for those of us who care about  
6     health equity specifically and equity in general.  
7     I think it is going to be very important for us  
8     to think strategically and work collectively to  
9     make our efforts to preserve and promote the work  
10    that is so important to all of us continues.

11                  I think this will be even more  
12    challenging than it has been in the past.    I  
13    think that makes our work even more important and  
14    our role as members of a federal advisory  
15    committee, again, really very important as a  
16    platform that will allow us to observe the impact  
17    of various actions and initiatives on the health  
18    of the public, and particularly on the diverse  
19    populations that are the focus of this committee.

20                  So I want to thank you for the work  
21    you have done and really issue a call to action

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1       for the work that we will now have to do that I  
2       think will require certainly vigilance and  
3       diligence, perhaps courage, as we continue to  
4       work on the things that are important to us. It  
5       has been a real pleasure working with all of you,  
6       and I look forward to continuing the effort.

7               I will give anybody else a minute if  
8       anybody wants to say anything or make any general  
9       remarks, but I do want to keep us on time, and I  
10      know we're going to have an update on the  
11      diversity culture audit that was done at CDC next  
12      on the agenda. But does anyone want to make any  
13      response? You could just say ``amen`` or ``ashe``  
14      or whatever you're feeling.

15      DR. WOOTEN:   Lynne, this is Wilma Wooten. I  
16      don't know if this is the time, Leandris, to  
17      bring up the issue that I emailed you about, but  
18      it kind of speaks to future and continuation of  
19      our efforts.

20               The --

21               CHAIR RICHARDSON:   So Wilma, I think

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1 I know where you're going. I think we actually  
2 are going to bring that up later in the agenda -  
3 -

4 DR. WOOTEN: Okay.

5 CHAIR RICHARDSON: -- because that is  
6 definitely more than a one-minute conversation.

7 DR. WOOTEN: All right. Thank you  
8 very much.

9 CHAIR RICHARDSON: Absolutely,  
10 thanks. Anybody else?

11 (No audible response.)

12 CHAIR RICHARDSON: Okay. Is Dr.  
13 James Nelson on the line?

14 DR. LIBURD: So Lynne, this is  
15 Leandris.

16 CHAIR RICHARDSON: Yes?

17 DR. LIBURD: I was just told that Dr.  
18 Nelson had a family emergency that has caused him  
19 not to be able to join us today.

20 CHAIR RICHARDSON: Oh, I am sorry to  
21 hear that.

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1 DR. LIBURD: Yes, I am too. We just  
2 heard about it just within the last 15 minutes,  
3 so we will, with your permission, go on to our  
4 next presentation --

5 CHAIR RICHARDSON: Yes, okay.

6 DR. LIBURD: -- by Ana.

7 CHAIR RICHARDSON: Okay. So we are  
8 now moving to the update on the Workforce  
9 Diversity Indicator activity. You all will  
10 recall that the CDC was working with the National  
11 Collaborative for Health Equity on what I believe  
12 was a Robert Wood Johnson-funded effort to look  
13 at this, if I have that correctly. But whether  
14 I do or not, we will now hear from Ana Penman-  
15 Aguilar to tell us the status of that activity.

16 DR. PENMAN-AGUILAR: Thank you,  
17 Lynne.

18 There are a couple different aspects  
19 to this presentation. One is related to the  
20 workforce diversity indicators that we are  
21 developing at CDC. The other aspect is more

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1 broad, and so I will start with that, and that  
2 relates to the National Collaborative for Health  
3 Equity.

4 As Lynne mentioned, they are funded  
5 by Robert Wood Johnson to develop measures, and  
6 it's a broad health measurement activity, so it  
7 covers many domains. It covers health outcomes  
8 both for children and for adults. It covers  
9 income, education, employment, physical  
10 environment, social environment, housing,  
11 safety, and access to quality healthcare, so this  
12 is a bit distinct from the workforce diversity  
13 indicator discussion, so I will start with this.

14 So in response to the recommendation  
15 from the subcommittee that we develop indicators  
16 of health equity, we did an environmental scan  
17 of efforts across the country that were doing  
18 similar things, and we were very excited by the  
19 work of Brian Smedley's group within the National  
20 Collaborative for Health Equity, their work on  
21 the Health Opportunity and Equity Measures

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1 project.

2                   So as was mentioned earlier, Dr. David  
3 Williams, he is on the advisory committee, and I  
4 believe he is the chair. I am also on the advisory  
5 committee, and we at CDC have been doing a lot  
6 of back-and-forth with the project, connecting -  
7 - David and I have been connecting -- he is on  
8 the call, David Huang, and I have been connecting  
9 them with SMEs, subject matter experts, for the  
10 data sources that they're using in their  
11 projects, because they're using a lot of CDC  
12 data.

13                   So just to give you a little  
14 background, and I did send out a one-pager, the  
15 project has been launched to start a new  
16 conversation about the opportunity gap to develop  
17 metrics that can be used to chart progress toward  
18 health equity, so the primary goals are to  
19 reframe the health disparities conversation in  
20 the context of health equity and opportunity and  
21 to develop a set of broadly accessible measures

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1 to illustrate gaps and opportunities to achieve  
2 health outcomes.

3 So this is one of the things that was  
4 particularly appealing to us about this project,  
5 that it really took a new -- a different look at  
6 disparities, not in terms of deficits in health,  
7 but in terms of opportunities, and it's also  
8 multisectoral in its approach because experts  
9 tend to focus on inequities in their field and  
10 miss how solutions are interconnected.

11 So the National Collaborative for  
12 Health Equity will be developing a framing  
13 document that lays out the theoretical framework,  
14 a state-level analysis that identifies the  
15 magnitude of relative and absolute disparities  
16 in health outcomes, and a national-level report  
17 that depicts opportunity gaps across the country.

18 So I will pause to see if there are  
19 any questions on this particular aspect of the  
20 presentation.

21 (No audible response.)

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1 DR. PENMAN-AGUILAR: Okay. And I  
2 will also add that the idea is that we hope to  
3 add value to the collaborative, but we certainly  
4 expect that what the collaborative learns and  
5 develops will be of use to the CDC, and that's  
6 the goal - to identify things that they are doing  
7 that we may want to incorporate in our work here  
8 at CDC.

9 CHAIR RICHARDSON: Ana, is there any  
10 more detail on the timeline for specific types  
11 of measures?

12 DR. PENMAN-AGUILAR: Well, they have  
13 done a teaser analysis, so the principal actors  
14 have done a teaser analysis, and that was of  
15 several indicators of health outcomes, income,  
16 and social environment, and that confirms the  
17 methodological approach. It showed that they were  
18 able to share findings for each indicator and  
19 build an indicator profile for a state, and show  
20 regional patterns. But in terms of the timeline  
21 for the overall project, all I really know is

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1       that we're talking about within this calendar  
2       year.

3                   CHAIR RICHARDSON:   Okay.   Thank you.  
4       Are there other questions for Ana?

5                   DR. ROSS:   Yes -- this is Will Ross  
6       again.   I appreciate this much more egalitarian  
7       approach on opportunity, an access-based  
8       approach.   I think it's much more positive.

9                   I wanted to hear that, while we are  
10      doing this, we're still ensuring there is true  
11      intersectionality in designing this framework,  
12      and intersectionality relates to our policy  
13      advocates and people with the National Centers  
14      in D.C., people like Nadine Gracia and others,  
15      and so do we feel that we have the right personnel  
16      from the policy framework to help drive this?   I  
17      know you mentioned David Williams, but you didn't  
18      mention anyone else.

19                   DR. PENMAN-AGUILAR:   Oh, it's an  
20      impressive list of folks.   I wish I could  
21      remember more names off the top of my head.

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1 CHAIR RICHARDSON: It's on their  
2 website, I think.

3 DR. PENMAN-AGUILAR: It is, it is.

4 MR. ROSS: I will go online. Don't  
5 worry, I will look for it.

6 DR. PENMAN-AGUILAR: Certainly with  
7 David being represented, I can't imagine that  
8 intersectionality will be neglected, since he is,  
9 very much the person who has advanced  
10 intersectionality.

11 We will be looking at ranking  
12 indicators by race, ethnicity, income, education,  
13 and place, and so there are the ingredients for  
14 a robust intersectional look at things.

15 DR. RO: Well, this is Marguerite,  
16 and I think this is really great and exciting  
17 work, and I think the finding of opportunity is  
18 one that also gives hope.

19 I will say that there are so many  
20 efforts right now going on around data dashboards  
21 and such indicators, and particularly ones that

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1 are at a lower level, you know, that address  
2 either the county level, or for instance, the Big  
3 Cities Health Coalition that NACCHO organizes has  
4 developed a data dashboard for big cities, and  
5 while I think it is helpful to have the state  
6 view, really a lot of the innovation and the need  
7 to address opportunities happens at a very local  
8 level. To the degree that the work can connect  
9 to what is happening at a more disaggregated  
10 level, I think the better off we will all be.

11 DR. PENMAN-AGUILAR: Yes, and there  
12 is also work happening in HHS related to Public  
13 Health 3.0, which is also more focused at a  
14 community level, so we will have a meeting in  
15 April, and I will definitely bring that  
16 perspective, and I can bring back information  
17 from that meeting.

18 MS. WILSON: Ana, this is Cheri  
19 Wilson. I had a quick question: how do you -- I  
20 think maybe many of us have heard about the two  
21 new bills in the House and Senate that have been

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1       proposed that would block federal funds for a  
2       federal database on geospatial information to  
3       identify community racial disparities.     So  
4       Marguerite, getting back to what you just said,  
5       do we have any idea how that can potentially  
6       adversely impact data collection or looking at  
7       those data?

8                     DR. PENMAN-AGUILAR:    I haven't seen  
9       that information and I don't have an answer for  
10      you.

11                    MS. WILSON:    Okay.

12                    DR. PENMAN-AGUILAR:    Yes.

13                    MS. WILSON:    Leandris, would you like  
14      me to send that out to you or someone to  
15      distribute to the HDS as something to look at?

16                    DR. LIBURD:    Yes, that would be good.  
17      Thank you.

18                    MS. WILSON:    Okay.   It's all over the  
19      public health list serves, so thank you.

20                    DR. LIBURD:    I just wanted to add to  
21      Will's question --

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1 CHAIR RICHARDSON: It's a little bit  
2 hard to hear you, Leandris.

3 DR. LIBURD: Okay. I just wanted to  
4 add in response to Will's question about policy  
5 indicators and the HHS Office of Minority Health,  
6 they are aware of this activity, very, very  
7 interested in it, and I believe they are waiting  
8 to have it evolved further before really reaching  
9 out to Brian Smedley and his group separately and  
10 his collaborators to talk more about policy  
11 outreach.

12 DR. ROSS: Thanks, Leandris.

13 DR. RO: This is Marguerite, I am  
14 thinking about the indicators... I don't know if  
15 it would work for Healthy People 2030 because it  
16 isn't done yet, but it would be interesting to  
17 make sure that this work also helps to inform  
18 that next effort.

19 DR. PENMAN-AGUILAR: Right, and it  
20 has begun, and Leandris has been at the center  
21 of it, so there will be plenty of opportunity for

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1 conversation within the office that can then feed  
2 the work of Healthy People 2030.

3 Okay. So I am going to move on to  
4 the presentation about indicators of health and  
5 healthcare workforce diversity.

6 CHAIR RICHARDSON: Workforce  
7 diversity, thank you.

8 DR. PENMAN-AGUILAR: So each of you  
9 should have a slide set in email, and I would  
10 like you to open it, please. And I will try to  
11 remember to ask you to advance slides.

12 So starting with the first slide which  
13 you see.

14 CHAIR RICHARDSON: And Ana, it is  
15 becoming a little hard to hear you.

16 DR. PENMAN-AGUILAR: We're just doing  
17 some technical things in the room here to make  
18 sure that you can hear me and that I can view the  
19 slides.

20 (Pause.)

21 DR. PENMAN-AGUILAR: So on the second

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1 slide, you see a list of folks on the workforce  
2 diversity indicator team, and this has been a  
3 wonderful and very rewarding effort. This has  
4 just been fabulous to have the work of Brittany  
5 and Jeff Hall, who is the Deputy Associate  
6 Director for Science; David from NCHS; Ramal  
7 Moonesinghe, mathematical statistician; myself.

8 The presentation will include problem  
9 statement, et cetera. We're on the problem  
10 statement slide.

11 So this represents some of the work  
12 of our literature review and things that those  
13 of us on the phone are well aware of, so it is  
14 important that the workforce adequately reflects  
15 the population served. We know that by 2042,  
16 the country is expected to become majority  
17 minority.

18 CHAIR RICHARDSON: Ana, I know I'm  
19 having problems --

20 DR. PENMAN-AGUILAR: Okay.

21 CHAIR RICHARDSON: -- hearing. That

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1 is much better.

2 DR. PENMAN-AGUILAR: All right.  
3 Okay. Now I have two microphones.

4 As I just said, we know that by 2042,  
5 the country will be majority minority, yet racial  
6 ethnic minority groups remain underrepresented  
7 in health and healthcare workforces, so we expect  
8 that health disparities will increase if  
9 workforce representation does not improve, and  
10 we have noticed that for workforce diversity  
11 measurement and monitoring, the national and sub-  
12 national indicators are limited.

13 And tying this to CDC's mission, our  
14 mission is to work 24/7 to protect America from  
15 health, safety, and security threats, and this  
16 involves routinely taking the pulse of our  
17 nation, and this includes social determinants of  
18 health and other determinants of health  
19 disparities.

20 So the purpose of this project is to  
21 improve understanding of diversity in the U.S.

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1 health and healthcare workforce; assess the state  
2 of diversity; expose measurement gaps; frame  
3 diversity as a social determinant of health that  
4 must be addressed to advance health equity. So  
5 for this reason, we are developing indicators of  
6 diversity through a health equity lens.

7 This actually builds on a workforce  
8 diversity indicator that was developed for  
9 Healthy People 2010, and it complements the  
10 social determinants of health indicators that are  
11 in Healthy People 2020, and we anticipate that  
12 it will complement the indicators in Healthy  
13 People 2030.

14 This slide shows you that in Healthy  
15 People 2010, there was an indicator of diversity,  
16 and Dr. David Huang, who is on the call, actually  
17 worked on this indicator. It was based on the  
18 proportion of members of underrepresented racial  
19 and ethnic groups specifically. For example, this  
20 slide shows the number of degrees awarded by  
21 accredited allopathic medical schools to AIAN

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1 Native persons, so this is one element in the  
2 objective. Next slide.

3 So we anticipate that this will help  
4 -- it will lead to understanding the state of  
5 health and healthcare workforce diversity,  
6 encouraging actions to improve diversity, and  
7 perhaps more importantly, promoting better-  
8 focused actions to improve diversity. It will  
9 lead to understanding gaps in what can be  
10 assessed, encouraging collection of new data  
11 elements, and I should add perhaps new methods  
12 for combining data elements to really look at  
13 intersectionality promoting consideration of  
14 health and healthcare workforce diversity as a  
15 social determinant of health. This is also one  
16 of the goals.

17 And ultimately, this benefits the  
18 public because there will be a health and  
19 healthcare workforce that is better-equipped to  
20 improve health, and we expect to reduce health  
21 disparities. Next slide, please.

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1                   We have conducted an environmental  
2           scan of datasets measuring health and healthcare  
3           workforce diversity. Brittany, who is on the  
4           call I believe, has worked with Jeff to develop  
5           an annotated bibliography. She also developed two  
6           justification statements, and we have been  
7           conducting key informant and stakeholder  
8           consultations.

9                   And in terms of what is ahead, we  
10          intend to keep consulting with informants and  
11          stakeholders as we develop workforce diversity  
12          indicators. We are starting with a teaser  
13          indicator for a diverse workforce. Brittany is  
14          putting together a spreadsheet of all the  
15          different data sources, and we're looking at the  
16          strengths and weaknesses of those, and we're  
17          thinking about methods for combining data points.

18                  And then it will expand to other  
19          dimensions of the healthcare workforce. Once we  
20          have learned what we can learn from this  
21          process, we'll expand to the public health

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1 workforce, which will be a bit more challenging,  
2 and then once we have the indicators developed,  
3 we will measure workforce diversity and produce  
4 a report with a gap analysis in this calendar  
5 year. Next slide, please.

6 So I wanted to talk a little bit about  
7 what we have learned, and I think having Dr. Jeff  
8 Hall and Ms. Brittany Ashkenazi on our team has  
9 been good because it has allowed us to think  
10 about ideally what would we want to know as it  
11 relates to workforce diversity beyond  
12 demographics. Next slide, please.

13 So here you see a slide that was  
14 shared by the Diversity and Inclusion Management  
15 Program within the office. This slide is not  
16 meant to imply that these elements of diversity  
17 carry equal weight.

18 When Dr. David Williams came to CDC  
19 to present on diversity and health disparities,  
20 he presented four different ways of looking at  
21 diversity, and I will mention a couple just

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1       because I want you to understand that this is not  
2       snowflake diversity.

3               Dr. Williams described snowflake  
4       diversity as the point of view that we are all  
5       individuals just like snowflakes. Because each  
6       person is unique, we should not attend to group  
7       differences in any substantive way. That is not  
8       what we are intending to communicate with this  
9       slide.

10              This slide gives the breadth of  
11       characteristics encompassed by diversity, and --  
12       and I think our perspective would follow what he  
13       called critical diversity, which is the equal  
14       inclusion of people from all backgrounds.

15              So now, Dr. Jeff Hall will talk about  
16       aspects of diversity beyond characteristics, and  
17       these are other aspects that we would ideally  
18       want to measure.

19              DR. HALL: Thank you, Ana.

20              One of the reasons that we wanted to  
21       include this next section of slides in the

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1 presentation is to give you an idea of the extent  
2 to which we are trying to get a good sense of  
3 what is involved in the measurement of diversity,  
4 as well as give you just a little bit of an idea  
5 as to how much of a challenge it is that we face  
6 when it comes to being able to move this project  
7 forward.

8           What you're going to see in the next  
9 couple of slides or so are simply an organizing  
10 tool.     The charts themselves specifically  
11 represent some collective aspects of diversity  
12 that we saw emphasized and discussed and  
13 addressed in various ways in the literature, and  
14 also identified in a variety of different ways  
15 in association with the environment scan that we  
16 conducted.

17           As you might expect, the charts  
18 displayed there in the presentation contain the  
19 population characteristics that Ana just  
20 mentioned in association with the slide provided  
21 by the Diversity and Inclusion Office, but also

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1 contain other elements that sometimes don't get  
2 considered when it comes to being able to have a  
3 more focused conversation about diversity and its  
4 measurement.

5                   So in this respect, what we wanted to  
6 do is to provide just an idea of some of the  
7 things that were spoken to beyond those  
8 population-level characteristics, and  
9 specifically, we wish to just give you a brief  
10 bit of information about some of the structural,  
11 environmental, and competency-related elements  
12 that were touched on in various ways in the  
13 environmental scan.

14                   So again, please keep in mind that  
15 this literature is very deep and very wide, so  
16 we wanted to give you just an idea as to some of  
17 the things that we saw in terms of the richness  
18 of the literature. So as an example of that  
19 first box that you see is dedicated to structural  
20 characteristics. We saw indicators examined such  
21 as representational measures, and in this

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1       respect, that is denoted by the box, for cultural  
2       representation. And an example of one of the  
3       things that obviously has been captured in this  
4       domain are measures assessing the proportion of  
5       professionals from target groups in the workforce  
6       as a whole as well as in relation to their  
7       presence in specific professions.

8               With respect to concordance measures,  
9       we saw that the literature also emphasized the  
10      necessity of examining the proportion of  
11      professionals from target groups in relation to  
12      the proportional representation of those same  
13      target groups in the populations served.

14             And lastly, addressing one additional  
15      piece of this box of structural characteristics  
16      that we're focusing on here, it was emphasized  
17      that the presence and nature of inclusion-  
18      centered activities such as those focused on  
19      retention, recruitment, and training must be  
20      emphasized.

21             One other part that we thought should

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1 be brought out in this presentation focuses on  
2 the component related to organizational  
3 governance, and more specifically, the  
4 subsections of literature that we found related  
5 to this part felt that it was very critical to  
6 examine representation of the entire group, not  
7 just in terms of their placement in front-line  
8 positions, but also across the various levels and  
9 layers and professional tiers as well as within  
10 supervisory and board-level positions within  
11 organizations and different occupational  
12 structures.

13 We saw in the literature that this was  
14 something that was very highly and strongly  
15 emphasized because those different levels of  
16 professional service have varying levels of  
17 involvement where participation in the making of  
18 critical decisions is concerned. So that was  
19 something that also was highlighted very  
20 significantly and very directly as a component  
21 of the organizational piece that requires some

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1 attention.

2 And beyond just simply talking about  
3 representation, organizational structures were  
4 focused on with respect to characteristics such  
5 as the presence of policies, plans, strategies,  
6 and agendas that were diversity-focused and the  
7 extent to which the organizations in the  
8 professional context of operations took specific  
9 actions to advance or enforce diversity-centered  
10 activities.

11 With respect to the next element of  
12 the charts that we present to you, I think we can  
13 all agree that it's not just enough to focus on  
14 representation or to talk about the  
15 organizational structures within which people  
16 work. We also have to pay some attention to the  
17 actual climate or environment within which the  
18 work itself takes place.

19 So in this regard, some of the various  
20 measures of climate or environment that were  
21 identified included things such as the actual

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1 movements of members of focal populations and the  
2 available career paths through organizational  
3 structures and within specific professions. One  
4 of the ways that this was tapped into was by  
5 examining the number or proportion of persons  
6 promoted from specific targeted groups or that  
7 were participating, for example, in specific  
8 types of career pathing programs.

9 We also saw and alluded to the fact  
10 that some emphasis was given to assessing the  
11 character of the climate by examining things such  
12 as the number of formal complaints that were  
13 submitted as well as obtaining some larger  
14 assessment of employee and management attitudes  
15 and practices as it relates to diversity issues.

16 So in this respect, beyond population  
17 characteristics and beyond structural  
18 characteristics, it has been emphasized that the  
19 climate is an essential component of what is  
20 captured where the measurement of diversity is  
21 concerned.

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1           And lastly, we recognize that there  
2           is significant interest in competence and in how  
3           skilled personnel are with respect to the ability  
4           to render culturally and linguistically  
5           appropriate services. So one specific case of  
6           what we saw in the literature related some of the  
7           individual staff-level characteristics of  
8           persons providing health and healthcare services  
9           as well as organizational characteristics to  
10          aspects of the national CLAS standards.

11          And in this particular respect, the  
12          type of domains that were given attention  
13          included but were not limited to aspects such as  
14          leadership support, which, for example, is  
15          assessed by looking at whether organizational  
16          leaders and governing bodies actually value  
17          effective patient-centered communication, and  
18          whether the type of commitment that they exhibit  
19          something that is considered to be visible to  
20          both their lower-level staff as well as the  
21          clients that they serve.

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1           A second example of one of the domains  
2       that received emphasis involves community  
3       engagement, and some of the questions posed with  
4       respect to the measurement aspects in that regard  
5       included whether or not there is demonstrable  
6       progress in terms of proactive efforts designed  
7       to effectively engage subgroups in communities  
8       where service is being provided.

9           Lastly, language services provision  
10      was a domain that received focus. In this  
11      particular respect, it was considered to be  
12      critical to take a look at the extent to which  
13      language assistance is required and rendered and  
14      how this relates to the ability of an  
15      organization to meet the needs of its service  
16      population.

17           So what we were trying to communicate  
18      in terms of providing the final portion of your  
19      presentation is a bit of information about the  
20      complexity of diversity measurement. We're not  
21      going to be able to, of course, with this

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1 particular project get into all of those  
2 different dimensions and all these different  
3 aspects. But we wanted to be sure that you were  
4 aware that we examined these factors and tried  
5 to develop a feasible position with respect to  
6 how we would begin to move our project forward.

7 So at this particular point, I will  
8 turn the presentation back over to Ana, and we  
9 can deal with any additional questions you may  
10 have.

11 CHAIR RICHARDSON: Thank you for  
12 that. So is that the end of the presentation?

13 DR. PENMAN-AGUILAR: I can wrap up in  
14 30 seconds.

15 CHAIR RICHARDSON: Okay, great.

16 DR. PENMAN-AGUILAR: Thank you so  
17 much, Jeff, and in terms of challenges we are  
18 facing, I would say certainly measurement gaps,  
19 places where data are not collected, would help  
20 us understand diversity better. Because of this,  
21 it will be difficult to get to more than just

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1       certain           population           characteristics.  
2       Nevertheless, we are determined to have this be  
3       more than a snapshot of race, ethnicity, or race,  
4       ethnicity, and sex. We have some ideas that we  
5       will test out in the physician indicator  
6       development. And another challenge is just  
7       continued alignment with stakeholders, so we want  
8       to be in conversation with other stakeholders.  
9       Thank you.

10                   CHAIR     RICHARDSON:       Are     there  
11       questions for Ana or Jeff? Maybe I will start.  
12       I thank you for this very comprehensive  
13       presentation of the deep dive that you have taken  
14       into how to think about and look at and assess  
15       diversity, particularly in the context of the  
16       workforce. Can you maybe talk a little bit now  
17       about how you're going to operationalize this  
18       very impressive framework into metrics, and what  
19       are the next steps?

20                   DR.   PENMAN-AGUILAR:     Well, I would  
21       say the first step is to do the teaser analysis

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1 with physician diversity, and a lot of what we  
2 can do will be limited by the data that are  
3 available. So we will obviously have this entire  
4 framework in mind as we look at the data points  
5 that we have to work with, and we will try to do  
6 justice to the principles behind diversity in our  
7 measurement, but it will probably come down to  
8 the variables that we have, and we expect that  
9 we'll have race, ethnicity, sex, geography, and  
10 age, perhaps, so we would look at race,  
11 ethnicity, sex, and geography as dimensions of  
12 diversity.

13 I think one of the ways we could even  
14 use age or year of graduation from training would  
15 be to see whether our cohorts are becoming more  
16 or less diverse, so these are just some practical  
17 thoughts, and as Jeff said, when it comes down  
18 to the practicalities. However, we want you to  
19 know that we have not forgotten the other  
20 important things that Jeff has just shared with  
21 all of us.

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1 DR. HALL: And one additional thing I  
2 will add -- and thank you, ladies and gentlemen.  
3 I know I flew through the presentation of the  
4 nuances of the framework. It helps to be able  
5 to lay out a lot of these conceptual parts  
6 because, as Ana mentioned, while there are going  
7 to be some obvious limitations with respect to  
8 what we can do with existing data, but having  
9 explored the literature and by beginning to  
10 create such a framework, allows us to also begin  
11 to develop some aspirational goals with respect  
12 to what might be possible to capture if  
13 opportunities were to present themselves for  
14 example to participate in new measurement  
15 activities where diversity is concerned.

16 So the framework that we presented has  
17 a lot of stuff in there that is abstract and that  
18 might be very difficult to measure within public  
19 health or even with respect to specific  
20 healthcare professions. But it helps to be able  
21 to think through the various pieces of diversity

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1       and parts of diversity that together constitute  
2       the environment in which these professionals that  
3       render service perform, and it gives us a good  
4       position with respect to what we are measuring  
5       and how that relates to the actual realities that  
6       we're trying to change when we're pushing  
7       diversity as a social determinant of health.

8                   DR. PENMAN-AGUILAR:   Yes, and I would  
9       like to add to that, it's one thing we talk about  
10      in our team that what we can't measure may be  
11      just as important to understand as what we can  
12      measure.   What we have done, we have actually  
13      created a matrix that has questions that we would  
14      want to answer if we had the data, and a lot of  
15      times, when you look at the cells that are filled  
16      in with the data sources, they're empty because  
17      the data just don't exist.

18                   And, I also don't want to minimize the  
19      importance of doing better with population  
20      characteristics.   This is something we have  
21      talked about at other meetings, that we really

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1       need to do better as a field with getting to more  
2       of the characteristics that are listed in the  
3       framework.

4                   CHAIR RICHARDSON:   Okay.   I want to  
5       leave some time for the committee members to ask  
6       questions --

7                   DR. ROSS:   This is Will Ross.   I  
8       appreciate Lynne's question about how you are  
9       going to operationalize it because, you have  
10      quite a lot of data, and I understand that. Jeff,  
11      you have mentioned how much of this is abstract  
12      and how much of this is going to be spelled out  
13      later, but still, we don't have a sense of  
14      prioritization.

15                   Among these -- within this framework,  
16      are there particular cells or areas that are  
17      going to be high priority based on the work that  
18      we presented -- the ACS recommendations we  
19      presented a couple years ago?   So what will drive  
20      prioritization in this effort?

21                   DR. PENMAN-AGUILAR:   That is a very

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1       good question.     I would say that population  
2       characteristics are definitely a priority.     I  
3       think anything that speaks to decision-making is  
4       a priority, since that is in the literature.  
5       Jeff, do you have anything to add?

6                     DR. HALL:   I do think that, like Ana  
7       said, the population characteristics and the  
8       decision-making piece are priorities.   I think  
9       part of what we're beginning with is again  
10      limited by where we are starting.     In  
11      characterizing the existing data sources, we are  
12      beginning from a position where we are  
13      essentially working with the decisions that  
14      people have made in the past, but what that may  
15      do is also create a space where we can then sort  
16      of say if we only focus at this part, then we're  
17      going to be very limited in how we can make  
18      movement forward in this particular space.   That  
19      could in turn give us the ability to evaluate to  
20      what extent we could move into the examination  
21      of some of the other parts of this chart that we

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1 have attempted to lay out for the group today.

2 DR. RO: This is Marguerite. I think  
3 the schema is really interesting, and it's one  
4 of the most organized schemas that I have seen,  
5 so thank you very much for doing this. I think  
6 this is actually in itself a contribution in  
7 addition to where there isn't data.

8 In terms of an interesting project  
9 that we might want to consider that would be  
10 another piece of information to add is many  
11 states through their Departments of Health have  
12 workforce plans that they are developing or have  
13 developed, and it would be interesting to look  
14 at -- for somebody like a graduate student or  
15 something, it would be interesting to look across  
16 state health workforce plans -- and to look at  
17 the areas that they touch under these schemas.

18 DR. HALL: I am glad you actually  
19 mentioned that because one of the activities that  
20 we did do as part of this work, when it came to  
21 some of the stakeholder conversations, we did

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1 talk to Dr. Arlene Lester, who is one of the lead  
2 experts with respect to the CLAS standards, and  
3 in some of those conversations, Dr. Lester did  
4 talk to us, for example, about the accreditation  
5 boards that exist within public health and how  
6 relationships with those types of groups and  
7 looking at the work that they do in terms of  
8 compliance activities might provide us with some  
9 opportunities to get a sense of what is being  
10 done on the ground where some of the local health  
11 departments are concerned.

12 DR. WOOTEN: Hi. This is Wilma  
13 Wooten in San Diego. I am on the public health  
14 accreditation board, and I was thinking along  
15 those lines. If you could go into how to elevate  
16 or promote it as a national standard, it would  
17 be a great idea to connect with staff and  
18 communicate it to local public health  
19 jurisdictions because the workforce development  
20 plan is one of the required documents in the  
21 application process for a voluntary national

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1 public health accreditation.

2 DR. PENMAN-AGUILAR: Great, and  
3 these are the types of intersections that we're  
4 wanting to think about right now, and I know  
5 Marguerite you had also mentioned some  
6 intersections with the de Beaumont Foundation and  
7 PH WINS, so we want to ensure that this is  
8 aligned, that we're learning from other people,  
9 that we offer value to others.

10 DR. WOOTEN: Yes. This is Wilma  
11 again. Both of those are organizations that have  
12 presented on diversity to the PH WINS project,  
13 so it would be really nice to avoid having  
14 competing models. They need to be integrated --

15 DR. PENMAN-AGUILAR: Okay.

16 DR. WOOTEN: -- in some way so that  
17 jurisdictions locally as well as states,  
18 territorial and trial jurisdictions are up to  
19 speed about what they should be focusing on. If  
20 everybody is in alignment, I think it would be a  
21 more coordinated approach, and we'll have overall

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1 better outcomes at the local level in the public  
2 health jurisdictions monitoring this  
3 information.

4 DR. PENMAN-AGUILAR: Yes, and I hear  
5 my Director saying yes, yes, so that's a sign  
6 that I think we're onto something, and we will  
7 be wanting to communicate with others who have  
8 similar goals and assure that we're aligned.

9 DR. LIBURD: Wilma, this is Leandris.  
10 So we have started conversations with our  
11 colleagues here at CDC, Liza Corso, and the  
12 Public Health Accreditation Board, and Tiffany,  
13 so we will continue to actually raise this issue  
14 as well, talking with them primarily about health  
15 equity, and it will be on the agenda for our next  
16 meeting of the subcommittee, so we will continue  
17 this conversation.

18 CHAIR RICHARDSON: Okay, great.  
19 Anyone else? We are a little over time, but I  
20 think this is an important topic, and it has been  
21 a good discussion.

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1 DR. GARZA: This is Mary. I just had  
2 a quick question: this is really interesting,  
3 this framework and everything, and I think this  
4 is really a contribution. Is there a timeline  
5 when some of these pieces are going to be  
6 operationalized and move forward? Do we have a  
7 deadline as far as getting this?

8 DR. PENMAN-AGUILAR: We want to have  
9 a report, some report, produced by the end of the  
10 year, and whether it's a report of a teaser  
11 analysis or beyond that, we want to present some  
12 data before the end of the year.

13 DR. GARZA: Okay.

14 CHAIR RICHARDSON: Thank you. Anyone  
15 else?

16 MR. VARGAS: This is Hector. I just  
17 want to add very quickly I concur with what my  
18 colleagues are saying about the contribution that  
19 this work is doing.

20 Just a suggestion if it is not already  
21 included to specifically call out gender identity

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1 in the analysis. I am certain that is probably  
2 part of the --

3 DR. PENMAN-AGUILAR: Absolutely.

4 MR. VARGAS: -- data gaps, so I think  
5 that is important because sexual orientation is  
6 already there, and I think that is important.  
7 And secondly, just to sort of reaffirm the  
8 importance of the gap analysis that you're going  
9 to do, and I hope that that gap analysis will  
10 include specific recommendations on how we can  
11 try to fill in those gaps where data does not  
12 exist or very little data exists.

13 DR. PENMAN-AGUILAR: Thank you,  
14 Hector, and that is at the very top of our list  
15 in terms of gaps, gender identity and sexual  
16 orientation.

17 CHAIR RICHARDSON: Okay. Well, thank  
18 you, Ana and Jeff. We look forward to continuing  
19 to hear on the progress as you move this forward.

20 DR. HALL: Thank you.

21 CHAIR RICHARDSON: And it is very

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1       important work and quite promising in the very  
2       thorough and comprehensive approach that you have  
3       taken.

4               So we have moved down the agenda.  
5       We're now at the open discussion period, and so  
6       Wilma, I know there is an item that you had wanted  
7       to bring to the HDS from the SDOH Think Tank.

8               DR. WOOTEN:     Sure, thank you, Dr.  
9       Richardson.

10              So the Social Determinants of Health  
11      Think Tank had a meeting last Friday, and there  
12      was a lot of discussion about making  
13      recommendations to the Director or Interim  
14      Director.     For example, making explicit  
15      recommendations about preserving and continuing  
16      the health equity and social determinations of  
17      health efforts, and identifying strides that have  
18      been made, and clarifying why we want to  
19      continue.

20              This is an opportunity to present a  
21      united voice to push for ensuring that those

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1        efforts continue. The discussion was, because we  
2        were having this meeting today, to bring the  
3        sentiments of the SDOH Think Tank to this group  
4        to request that a joint letter or recommendation  
5        be developed, and that is the first ask. Does  
6        this subcommittee want to do that? And if so,  
7        to form an ad hoc group to determine the content,  
8        and then that group would also bring back some  
9        strategic approaches, whether to send the  
10       recommendation to the current Interim Director  
11       or wait for the permanent Director to come  
12       onboard.

13                    There were two components that  
14       received a lot of discussion. Particularly,  
15       whether it is advantageous to send information  
16       now as well as when a new Director comes in, or  
17       wait until a permanent Director comes onboard?  
18       This is my proposal to the subcommittee.

19                    CHAIR        RICHARDSON:                Comments,  
20       discussion? I know some of you will recall we  
21       did have a similar discussion at our last meeting

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1       about putting together something, whether it was  
2       a letter or a report, but something to put in  
3       front of the new leadership of CDC, so I think  
4       we are very much on the same page with the work  
5       group.

6               I guess the questions are: Is this  
7       something the HDS wants to move forward with?  
8       And should we do it in concert with the Social  
9       Determinants of Health Think Tank?

10              DR. Iton:    This is Tony Iton.    I  
11       support that invitation that we should do it in  
12       concert with that work group, and I think that  
13       we should wait, and I suspect that we won't have  
14       to wait that long.

15              CHAIR    RICHARDSON:       Yes,    for    a  
16       permanent Director of CDC?

17              DR. ITON:   Yes.

18              DR. ROSS:   This is Will.    I agree  
19       with Tony Iton.   I think that we want to wait for  
20       maximal impact and maximal effect, and I do think  
21       that we should speak with one voice, and so I

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1 would urge us to have a unified document.

2 DR. RO: This is Marguerite. I second  
3 that.

4 CHAIR RICHARDSON: Okay. I am  
5 definitely hearing a rapidly forming consensus.  
6 Leandris, I guess a question I have for you is,  
7 or Wilma, if this was discussed, would this be  
8 most impactful if the think tank and this  
9 subcommittee worked together to create a document  
10 which we then present to the ACD for its  
11 endorsement so that it actually came from the  
12 full ACD rather than the subcommittee and think  
13 tank? Is that --

14 DR. WOOTEN: That was the intent,  
15 Lynne, yes.

16 CHAIR RICHARDSON: Okay. So  
17 Leandris, if the ACD meeting occurs in April, at  
18 what point would the agenda close? Just so we  
19 know, can we still get onto the April meeting  
20 agenda?

21 DR. LIBURD: Yes. The agenda doesn't

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1 close until generally 30 days before the meeting,  
2 and we have had a standing spot on the agenda for  
3 the Health Disparities Subcommittee --

4 CHAIR RICHARDSON: On the agenda?

5 DR. LIBURD: Yes, on the agenda, so -

6 -

7 CHAIR RICHARDSON: So it could be  
8 presented at that time?

9 DR. LIBURD: Yes.

10 CHAIR RICHARDSON: Okay. And it  
11 could be also referenced in the field report as  
12 well.

13 DR. LIBURD: Exactly, but deferred,  
14 that the full report would come with your report.

15 CHAIR RICHARDSON: Very good. Are  
16 there any questions or concerns about the course  
17 of action upon which we seem to be embarking?

18 (No audible response.)

19 CHAIR RICHARDSON: Anyone?

20 (No audible response.)

21 CHAIR RICHARDSON: All right. So I

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1 think now what we need are a couple of individuals  
2 who will actually do the work of drafting a  
3 document that could then be circulated for review  
4 by both groups, presumably. Wilma, do you have  
5 a working draft, yet?

6 DR. WOOTEN: No, no working draft. I  
7 think we thought about pulling from some of the  
8 prior recommendations --

9 CHAIR RICHARDSON: Yes.

10 DR. WOOTEN: -- and then wherever  
11 there were any gaps, sentiments that we wanted  
12 to move forward, we would include that as well,  
13 but our recommendation or suggestion was to form  
14 this ad hoc group. I am thinking the chairs of  
15 the Social Determinants of Health Think Tank plus  
16 the chairs of the subcommittees, STLT  
17 Subcommittee and Health Disparities  
18 Subcommittee, and anyone else who would want to  
19 be involved. We can maybe align it with some of  
20 the upcoming meetings, and I know that you have  
21 some additional meetings coming up.

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1 CHAIR RICHARDSON: Right. Well, I am  
2 happy to personally be involved. I certainly  
3 would like to have at least one more volunteer  
4 from the subcommittee because I do not want to  
5 become the rate-limiting step to this process.

6 DR. WOOTEN: Yes, absolutely. And  
7 that is a decision that doesn't need to be made  
8 now, but could be made --

9 CHAIR RICHARDSON: Yes. Well, I  
10 actually would like to get a sense of who is  
11 interested or willing to volunteer now, and then  
12 we can follow up with you and try to convene a  
13 meeting of --

14 DR. WOOTEN: Absolutely.

15 CHAIR RICHARDSON: -- whoever it is  
16 who is going to be involved and figure out the  
17 process and a timeline. Certainly I think we  
18 all would like to have this ready to present to  
19 the ACD at its April meeting, so I think that is  
20 the most important timeline.

21 DR. WOOTEN: Let's just assume that

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1 the permanent Director will not be onboard, is  
2 that what we're thinking, for April, or do you  
3 think that they would be?

4 CHAIR RICHARDSON: No, we think they  
5 probably will not be.

6 DR. WOOTEN: Yes.

7 CHAIR RICHARDSON: I guess my thought  
8 was that we should have it ready to go to be  
9 presented to the Director as opposed to waiting  
10 until there is a Director and then starting to  
11 write it --

12 DR. WOOTEN: Oh --

13 CHAIR RICHARDSON: -- and get --

14 DR. WOOTEN: -- absolutely --

15 CHAIR RICHARDSON: -- ACD approval.

16 DR. WOOTEN: Starting now is  
17 absolutely the intent. Where I was going was to  
18 make the recommendation to the ACD, and the ACD  
19 would present it to the permanent Director when  
20 they are onboard.

21 CHAIR RICHARDSON: Yes, that seems to

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1 be the strong consensus of the HDS that we would  
2 like to wait and present these recommendations  
3 to the permanent Director.

4 Okay. Any other comments? I guess  
5 we should anticipate for the possibility that we  
6 might need to modify them if there is some  
7 important change after we have a working draft,  
8 but I think that is relatively easy to do, but I  
9 don't want to wait and try to get approval at the  
10 October ACD meeting because then I feel like we  
11 may have missed the opportunity, you know.

12 DR. WOOTEN: I was not even  
13 insinuating that.

14 CHAIR RICHARDSON: Right, right, no,  
15 I understand, yes. But there is a possibility  
16 which was mentioned at the beginning of our call  
17 that the April meetings which include both this  
18 subcommittee and the ACD might be rescheduled if  
19 we are close to having a new Director come onboard  
20 because it might be beneficial to have the new  
21 Director at the meeting, so right now we are

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1 holding the April date, but we will put everyone  
2 on notice that the date may change if say by May  
3 there would be a new Director in place. Maybe  
4 then the ACD meeting would be pushed back, so  
5 that's a possibility.

6 DR. WOOTEN: Certainly, but we can  
7 still get the work done --

8 CHAIR RICHARDSON: Exactly. And I  
9 think the bulk of what we're going to say is not  
10 going to change over the next few months.

11 DR. WOOTEN: Right.

12 CHAIR RICHARDSON: Okay.

13 DR. RO: Well Leandris, this is  
14 Marguerite. I would be happy to join that phone  
15 call.

16 CHAIR RICHARDSON: Excellent.

17 DR. ROSS: Well Marguerite, you and I  
18 are joined at the hip, and so if you join, I will  
19 be there.

20 DR. RO: I think Will and I are two  
21 of the departing members, so this can be our

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1 parting shot, as it were?

2 CHAIR RICHARDSON: Yes.

3 (Laughter.)

4 CHAIR RICHARDSON: Okay. I don't  
5 want to make it too big, and we certainly will  
6 take whatever draft is developed and bring it  
7 back to the whole HDS. We have another call  
8 before April, Leandris?

9 DR. LIBURD: We actually do not.

10 CHAIR RICHARDSON: Okay. Well, I  
11 feel though like we could do it by email, and if  
12 we have to schedule a call for purposes of  
13 discussing this document, then we might be able  
14 to do that on an ad hoc basis, but I would like  
15 to get input from the entire subcommittee. Well,  
16 I guess we would be meeting before the ACD, is  
17 that right? Yes.

18 DR. LIBURD: The office can  
19 coordinate the calls for the three of you, or  
20 however many will be part of the initial writing,  
21 and, we can provide a conference call number --

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1 CHAIR RICHARDSON: Right.

2 DR. LIBURD: -- so we can have time  
3 to get meetings on people's calendars, we just  
4 need to confirm from that it is Will, Marguerite,  
5 you (Lynne), and I don't know who else?

6 CHAIR RICHARDSON: Whoever is coming  
7 from the SDOH Think Tank, and perhaps the --

8 DR. WOOTEN: So it would be myself,  
9 the chair of the think tank, and then I would  
10 imagine we would probably solicit one or two  
11 other people, and we'll get that information to  
12 you through Judy.

13 CHAIR RICHARDSON: Very good.

14 DR. LIBURD: I think we could get  
15 people's schedules within the next month? Okay?

16 CHAIR RICHARDSON: Okay. I do want  
17 to take this time to declare the opening of the  
18 public comment period. Are there any members of  
19 the public on the phone who would like to announce  
20 themselves and address the committee at this  
21 time?

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1 MS. RICHARDS: Lynne, this is Judy  
2 Richards. I just wanted to add one piece of  
3 information since this is an open time, but the  
4 STLT Subcommittee is actually meeting on the 21st  
5 of March, so you might want to consider that in  
6 your timing. That is all.

7 CHAIR RICHARDSON: Thank you for  
8 that. Okay, one more time, here is the  
9 opportunity for members of the public who are on  
10 the phone who would like to address the  
11 committee.

12 (No audible response.)

13 CHAIR RICHARDSON: Okay. I see we  
14 are right at the hour, and so I don't want to  
15 hold people to make fatuous closing remarks. I  
16 think we have heard about some very important  
17 initiatives during this call, and we have taken  
18 on one action item, which I think we're quite  
19 committed to, and we will keep you updated on  
20 that and also on any potential changes to the  
21 meeting date in April. So unless somebody has

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1 something else urgent, with that, I will adjourn  
2 the meeting and bid you all a good afternoon.  
3 Thank you.

4 (Whereupon, the above-entitled matter  
5 went off the record at 3:01 p.m.)

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