Meeting Summary

State, Tribal, Local and Territorial (STLT) Subcommittee

Advisory Committee to the Director of CDC

Thursday, March 27, 2014
4:30 pm– 6:00 pm (EDT)

Call Objectives:

The objectives for this meeting are as follows:

- Review recent developments in Office for State, Tribal, Local and Territorial Support and CDC
- Review and act upon report and recommendations on social determinants of health sub-workgroup of the STLT Subcommittee
- Review progress and potential action steps on surveillance and information sharing activities at CDC, including National Surveillance Strategy
- Review and provide appropriate direction on Health Department of the Future Recommendations related to shared services, foundational capabilities, CHNA and financing

Chairperson: **David Fleming, MD**

Prepared by the Office for State, Tribal, Local and Territorial Support (OSTLTS)

Subcommittee Members present: John Auerbach, Dileep Bal, Terry Cline, Bruce Dart, Thomas A. Farley, Jonathan Fielding, David Fleming, James Gillan, David Lakey, Carol Moehrle, Jose Montero, Jewel Mullen, Lillian Rivera, Mary Selecky

CDC staff present (and announced): Judy Monroe (DFO), Robin Ikeda, Chesley Richards, Laura Seeff, Judy Lipshutz

Notes: Christina Valdes-Moreno (CDC Contractor)

I. Welcome/Call to Order

Dr. David Fleming welcomed the STLT Subcommittee members and the CDC presenters. Dr. Fleming took attendance and indicated there were enough members present for a quorum**.** All STLT Subcommittee members were asked to disclose any financial conflicts of interest:

    a. John Auerbach – no disclosures to report
    b. Dileep Bal - no disclosures to report
    c. Terry Cline- no disclosures to report
    d. Bruce Dart - no disclosures to report
    e. Thomas A. Farley – no disclosures to report
    f. Jonathan Fielding – no disclosures to report
    g. David Fleming – no disclosures to report
    h. James Gillan – no disclosures to report
    i. Carol Moehrle –no disclosures to report
    j. Jose Montero – no disclosures to report
    k. Lillian Rivera - no disclosures to report
    l. Mary Selecky – no disclosures to report

II. OSTLTS and CDC Update

Dr. Judy Monroe, Director of the Office for State, Tribal, Local and Territorial Support, provided a CDC update on several areas:

- **Open Leadership Positions at CDC:** 1) Director of the National Center for Environmental Health and Agency for Toxic Substances and Disease Registry (NCEH/ATSDR); 2) Director of National Center for Injury Prevention and Control (NCIPC) within the Office of Noncommunicable Diseases, Injury and Environmental Health (ONDIEH); 3) Associate Director of Policy, CDC (applications closed on March 25, 2014)
- **Public Health and Healthcare Collaboration -- one of CDC's three priority areas:** The Office of the Associate Director of Policy is leading a new workgroup of the ACD, which will work closely with the STLT Subcommittee to ensure coordination.
- **OSTLTS Updates**
  - ➢ Welcomed Heather Duncan as the new Director of the Public Health Associate Program (PHAP). Heather comes to OSTLTS from the Office of the Chief of Staff, where she has served as CDC's Deputy Chief of Staff since September 2010. There are 400 PHAPs embedded in STLT health departments. In the coming Fall, 166 new public health associates will join in the program
  - ➢ The Field Services Office, led by Kristin Brusuelas, will now focus on health system transformation.
  - ➢ Recruitment for lead of tribal support will begin soon.
  - ➢ The Prevention Status Report was launched in January 2014 and features reports on 10 key public health topics. Since its launch, there have been over 46,000 views and 1,700 downloads. Physical activity and healthcare-associated infections are two popular downloads.
- **CDC FY14 Budget**: Overall, CDC is pleased with the budget, which was an increase from the FY13 total budget. There are some challenges as the base budget continues to decline and the agency lost funding in a number of programs. There are, however, new opportunities such as the doubling of the block grant program which is being transferred

to OSTLTS to manage. As the block grant is funded through the Prevention for Public Health Fund (ACA), there will be some different reporting requirements compared to the past. There may also be new opportunities.

Discussion

- Comment: The loss of funding in FY14 for both the National Public Health Initiative (NPHII) and the Community Transformation Grants (CTGs) will create gaps around valuable work
- Question: There were increases in chronic disease funding – are there opportunities to consider in these grants?

    ➢ Response: Community Transformation Grants (CTGs) went away, but the dollars associated with CTG can all be accounted for. Chronic disease funding increased and will result in release of a new FOA shortly. The total FY14 level for Chronic Disease Prevention and Health Promotion is $1.15B ($7.11M in base funds and $446M in PPHF funds), which is $9.8M below the FY12 level. Examples of specific program levels include:

        o heart disease and stroke programs which increased by $72.9M -- Million Hearts received $4M;
        o diabetes prevention increased by $72.9M;
        o tobacco increased by $13.9M;
        o cancer prevention and control decreased by $15.2M.
        o CTGs were eliminated but a new $80M Community Prevention Grants program was established.
        o REACH received $50M, which is $3.9M below FY12, but considerably higher than FY13.
        o National early child care collaboratives received $4M, which is $1M less than the Healthy Weight Task Force line received in 2012.

- Suggested Action: Form a workgroup of 4-6 members of this subcommittee to help OSTLTS look at budget/finance related opportunities and provide recommendations, especially as they relate to changing accountability issues related to the block grant. It makes most sense to establish such a group within next few weeks with a focus on government funding streams.

    ➢ The Subcommittee agreed to establish the budget/finance workgroup.
    ➢ Subcommittee members who are interested in participating should reach out to Dr. Judy Monroe ASAP.

III.   Financing
Dr. Laura Seeff, Senior Advisor for Health Systems, Office of the Associate Director for Policy at CDC; provided a progress report on STLT Subcommittee recommendation related to financing. Since the last meeting of this subcommittee the CDC finance committee has further clarified the two tracks of work and drafted a diagram to illustrate funding streams for governmental public health, healthcare, and the intersection of the two. Ultimately, the goal is to identify:

1. Innovative financing vehicles for evolving service delivery models

2. Sustained funding for health departments and the public health enterprise

The graphic (distributed) depicts streams of funding through traditional sources for health care (e.g., Medicaid/Medicare, private insurance, out-of-pocket payments, etc.) and traditional sources for public health funding (e.g., federal, state & local taxes, billing/fees revenue, grants). Newer, non-traditional funding sources, such as public-private partnership funds (e.g., social impact bonds, CDFIs), private funds (e.g., hospital community benefit, program related investments, community trusts), and publicly-funded innovation grants (e.g., CMMI awards) occupy much of the focus of current attention. Social determinants (and financial support for them) are seen in this depictions as critical to health care and public health.

CDC continues to grow its relationship with CMMI (CMS) to identify non-traditional funding sources and models. Specifically, CDC is supporting development and testing of a number of models that link clinical care coordination with risk factor control, changes in physical environment and social determinants of health. CDC is exploring new financing mechanisms for these models both internally and externally.

CDC has been working through a cross-CIO committee to pull together multiple efforts that will paint a full picture of the complexities of funding public health in the evolving healthcare arena. For example, the committee is exploring: potential partnership with shared savings delivery models, the continued need for delivery of traditional public health services, wrap around services (e.g., case finding, DOT) and the scope of the population that will remain unenrolled and implications for them on service delivery. The work of RESOLVE to define core services (i.e., foundational capabilities) for public health departments will also be part of the larger picture. Some activities underway (partial list):

- CDC has commissioned a series of white papers describing the current and potential future role of health departments and public health in the care delivery of ACOs .This effort will examine if public health could be a delivery partner in an ACO.
- A cross-CIO CDC internal committees is focusing on non-traditional financing models (where health care can intersect with public health)
- A cross-CIO CDC internal committee is focusing on billing and related capabilities for health departments
- OADP/CDC is working with GWU (Sarah Rosenbaum) and others in the field to conduct an assessment of baseline of the size and characteristics of the population likely to remain unenrolled in health insurance and implications for that population on continued service delivery.
- OADP/CDC is working to link plans of the new Public Health/Health Care collaboration workgroup of the ACD with STLT Subcommittee around common/overlapping issues.

Discussion
- Comment: This work has grown out of recommendations for the health department of the future recommendations. We appreciate the speed and clarity which CDC has picked this up. We look forward to continuing this discussion at our next meeting.
- Comment: The diagram is very nice. Suggestion was made to add 1115 waivers through Medicaid, as another opportunity given that it has resulted in directing significant dollars to public health initiatives.

IV.   **Social Determinants of Health (SDOH) Workgroup Report**

John Auerbach, Chair of the Social Determinants of Health Workgroup briefly introduced the workgroup members and a review of their deliberations to date. Workgroup members include: John Auerbach (Chair), Jonathan Fielding, Jose Montero, and Jewel Mullen (with support by Judy Lipshutz).

Background:
SDOH as an issue is receiving increasingly more attention in multiple settings. The Health Disparities Subcommittee (HDS) of the ACD will present recommendations to the ACD on April 24th, several of which relate to SDOH.

Actions of SDOH Workgroup:

- Propose formal endorsement of Health Disparities Subcommittee recommendations that will be presented to the ACD on April 24, 2014
- Propose 2 related recommendations that build out SDOH
  1. HDS Recommendation 2 (to identify and monitor indicators of health equity)

  Proposed STLT Subcommittee recommendation: *CDC should explore the available non-health data sources from other domains (e.g., housing, transportation, public safety, income) that are readily available and that offer insights into the impact of the social determinants of health. CDC should also explore ways STLT health agencies can collect and incorporate such data in their planning.*

  2. HDS Recommendation 6 ((Support training and professional development of the public health workforce to address health equity)

  Proposed STLT Subcommittee recommendation: *CDC should develop a plan to either leverage existing informational and skill-building training opportunities for STLT agencies on how to incorporate SDOH practices or how use of SDOH framework can be valuable in CDC funded and other public health activities taking place*

The Social Determinants of Health Workgroup will continue its work over the coming months to develop additional recommendations regarding the kind of action steps for the STLT Subcommittee to consider and ultimately take to the ACD. In the meantime, the Social Determinants of Health Sub-Workgroup welcomes discussion from this subcommittee on recommendations that have been developed. In addition, it would be helpful to hear ideas about how these may be integrated with HDS presentation to ACD in April.

Discussion

- Comment: There are government human services programs designed to address some of these social problems or social issues that also would be very valuable for us to know about. We should understand how extensive those are and consider them as potential predictors and potential modifiable factors to address health problems. The list of non-health data sources should include human services programs and maybe also include education, not only because they may be influential but also because they are more modifiable than factors like income.
- Comment: From a STLT governance and structure point of view, state and local boards of health should be part of this effort, both because of their advisory/oversight capability and because boards of health represent our community groups.

- Comment: The emphasis on the non-traditional public health workforce is where the rubber is going to meet the road. Training should be directed towards those groups. We need to start improving that part of the workforce at the state and local level.
- Comment: Similar recommendations are coming out of the public health/health care collaboration group, so alignment of those recommendations is important.
- Comment: The county rankings came out yesterday. Many do not realize how social determinants of health are affecting our communities. This is very important work.
- Comment: Washington and Oregon were provided as state examples of how hospital systems are doing CHNA and committed to making their communities healthier. These efforts include SDOH.

Action:
- It was proposed to officially accept the two recommendations by this subcommittee and forward those to the ACD in April. The proposal was adopted unanimously.

  Suggestion by Subcommittee member: Suggest that these recommendations be presented in April in conjunction with the Health Disparities subcommittee's recommendations. Dr. Jewel Mullen (serving on both the STLT Subcommittee and the Health Disparities Subcommittee) agreed to share these recommendations with the Health Disparities Subcommittee that will be meeting in a couple of weeks to figure out how to coordinate the two reports.

V.   Surveillance and Information Sharing: HIT/HIE/ELR/EHR
Dr. Chesley Richards, Director, Office of Public Health Scientific Services, CDC, provided an update on the National Surveillance Strategy and other related cross-CIO work.

Background
- In September, 2013, Dr. Frieden charged the Office of Public Health Scientific Services and senior leadership with developing a national surveillance strategy. This strategy is intended to address 4 key objectives:
  - Improve availability and timeliness of surveillance data to CDC programs, STLT agencies, and other stakeholders (public data)
  - Advance effective use of emerging information technology including electronic health records, mobile technologies, and cloud computing
  - Identify and amend or retire ineffective or unnecessarily redundant CDC surveillance systems
  - Maximize the effectiveness of available agency resources devoted to surveillance and the performance and coordination of our surveillance systems.

- The FY 2014 Omnibus Appropriations Bill includes language requiring CDC to work with state and local health officials to submit a report focused on opportunities to consolidate the various data collection systems in CDC. This report is due to Congress on July 17, 2014.

Activities
Since the fall, the Surveillance Strategy Workgroup has convened three meetings and provided substantial input in the strategy. Dr. Frieden, senior leadership and key external stakeholders including ASTHO and CSTE have reviewed the strategy and provided input as well.

The Surveillance Strategy is comprised of three main goals:

- Goal 1: Enhance the accountability, resource use, workforce and innovation for surveillance at CDC and in support of STLT agencies

- Goal 2: Accelerate the utilization of emerging tools and approaches to improve the availability, quality, and timeliness of surveillance data

- Goal 3: Through cross-cutting agency initiatives, improve surveillance by addressing data availability, system usability, redundancies, and incorporation of new information technologies in major systems or activities

Goal 1
- Launch of CDC Surveillance Leadership Board that will convene in late April 2014. An initial meeting of agency deputies to discuss the parameters and charter for this group has already taken place.
  - ➤ The Leadership Board will deal with some of our pressing strategic decisions around surveillance, such as the number of systems that exist, how programs work with states to fund, the problem of siloing as a result of funding methods, and workforce issues at a high and strategic level within the agency.
- Workforce Planning with OSTLTS, OPHPR, CSELS and OPHSS
  - ➤ This effort is intended to coordinate the workforce needed for surveillance and informatics at multiple levels. CSTE has already provided input and input will be sought from other partners
- Development of the *Health Information Innovation Consortium)* that would give CDC programs doing innovative work in surveillance and informatics a place to go to share with other programs, have it vetted, get advice and technical support, and connect with policy leads in agency.
  - ➤ This consortium is also envisioned as a place for STLT agencies who are working on similar types of projects could exchange ideas. (May 2014)

Goal 2
- Effective HIT policy engagement --
  - ➤ A few weeks ago, the meaningful use workgroup of the HIT policy committee, voted to remove Stage 3 meaningful use requirements in public health for ELR and syndromic surveillance. While that decision was reversed because of active pushback from many of the public health agencies, it exposed the importance of more effective CDC engagement on a high level in strategic policy issues around health information technology policy.
  - ➤ Karen DeSalvo, Director of Office of the National Coordinator for HIT (ONC) has requested that CDC have an ex-officio CDC member on the HIT policy committee; this request is working its way through HHS approval and represents a start for strengthening CDC's policy efforts around HIT in Washington.
- Creating a forum within CDC for vendor engagement (May 2014)
  - ➤ Currently, vendors are marketing to individual programs resulting in some of the siloing of programs including different approaches, different vendor products, and different standards. The numerous and different ways of collecting data and working on HIT issues is a problem.
  - ➤ CDC plans to develop a strategic vendor engagement in order to ensure a more coordinated relationship with vendors with the hope of easing their burden on states
- Supporting innovative informatics projects (May 2014)

> ➢ Through the consortium CDC will provide small grants for both CDC programs and external agencies to seed funding that can get innovative informatics projects off the ground and connect them to a peer group and a policy process so that the projects are aligned with the direction of CDC's main HIT activities.(FY2014)

Goal 3
- Initiative 1. Modernize National Notifiable Diseases Surveillance System (NNDSS).
  - ➢ In widespread recognition that NNDSS currently does not work well, CDC will be enhancing a NEDSS based system and trying to modernize it so that we can get all the data coming in as HL7 messaging in those states that use NEDSS. This is also appropriate for other systems that many states have developed. We see this as a first step for modernization so that data can be analyzed by state and local submitters in a way that is more effective than what we have now and can be used by the programs and not put the programs in the position of setting up duplicative or parallel data collection efforts.
- Initiative 2. BioSense Enhancement Initiative
  - ➢ BioSense has been around since after 9/11 and the anthrax attack. CDC conducted a strategic review of how it is functioning and found that the need for major upgrades to make it more functional. These are intended to especially help with analytics for local health agencies and will be more useful to CDC programs. The idea is that this platform can really live up to the vision that many people had for purposes of both situational awareness and surveillance in emergency departments in hospitals.
- Initiative 3. Acceleration of Electronic Laboratory Reporting
  - ➢ CDC plans to accelerate ELR from health departments. Currently, greater than 50% of reports are coming electronically from public health agencies. By 2016, CDC aims to increase ELR to over 80 percent of public health agencies.
- Initiative 4. Accelerate Electronic Mortality Reporting
  - ➢ Like ELR, CDC aims for 25 states to adopt electronic mortality reporting for at least 80% of deaths to public health agencies within 1 day of registration.

How will the Surveillance Strategy help us do our work?
- A key factor for agency programs and STLT agencies is to understand how the surveillance strategy will help us do our work
- External partners and internal leaders have expressed the importance of setting a strategic direction for how we do surveillance across the agency since it is a very distributed function
- The strategy will help us more effectively harness and support program and STLT initiated innovation and integrate with other agency efforts, particularly in informatics
- Short term initiatives (12-18 months) will demonstrate tangible improvements over the next few months to build that momentum to do other things

How will the Surveillance Strategy assist with Congressional Response?
- Currently, we do not have capacity for a single web-based system. However, we can certainly create major platforms and position ourselves to have fewer systems and have better, more timely data and data that can be used for multiple purposes
- This strategy will help us advance toward that goal.

Other Updates
- Appointed Acting Chief Public Health Informatics Officer (Brian Lee)
- External Partner engagement with CSTE, ASTHO, APHL, NACCHO, APHA, TFAH

STLT Subcommittee: Meeting Notes

Discussion

- Comment: It is nice to see a focus on IT and on consolidating systems. New York has worked a lot on electronic health records and we can subsequently do an entirely different type surveillance that includes health conditions and preventive healthcare services. We are able analyze huge numbers of electronic health records in an anonymous way. (e.g., how many people have high blood pressure, how many are obese, how many are receiving treatment for their high blood pressure, etc.) I wouldn't want this surveillance transformation to simply improve the reporting of the things we have done in the past, and close off the idea that something like what we've done in NY might become a national system as well. I suggest that as you move forward to think about how to incorporate new opportunities that come up.

  Answer: No, I would not close off that type of development over time. I think what we've tried to do with the initiatives so far could be framed as incremental innovation and improving existing efforts. We are also looking for opportunities for "disruptive" innovation to make existing efforts better. We are working with the Patient-Centered Clinical Research Network to look for opportunities. Through our innovation consortium and other routes, we want to hear about new innovation we may consider and at the same time improve any tangible systems we currently have.

- Comment: There are numerous IT programs in our agency and it is sometimes challenging to understand how to combine systems using gateways. Data enters so many ways and we are trying to work so there is common way for people to get information. The work you have outlined here is very important in moving public health forward.

- Comment: I would suggest thinking about how these surveillance systems and data can be more easily incorporated into CHNA. This will be helpful when we are working at the state and local levels with hospitals that are doing community health needs assessments, that we are bringing data that are relevant to them to the table and asking them for their data in that context, particularly as it relates to the last discussion on health disparities. We need information at this neighborhood level. Have you had any initial thoughts or scope of work that has helped tried to make this more available to hospitals and at the neighborhood level?

  Answer: We are on the steering group for PCOR, which is a network of 27-28 health care systems and consumer-based networks. Some are registries and some are more like surveillance systems. One opportunity is to think about public health, and with the subcommittee's participation and guidance, we can think about how to take advantage of these massive collections of EHRs and other types of health data and consumer data, and leverage that more effectively for surveillance. But this will not work with a traditional model where we define and collect the data just for our purposes. We then need to understand how to access existing data systems and to get knowledge and understanding. It will help to be able to access larger, clinical systems that will get us closer to getting timely data that are more actionable on a local level (e.g., by zip codes). All of this is critical to advancing CHNA work.

- Comment: A lot of areas are using commercial, for-profit vendors to do their CHNA work. It would be good if CDC could provide guidance on how these surveillance systems and data can be more easily incorporated into CHNA. Some of the commercial vendors use secondary data from our data sets but don't always make it available to us.

VI.   Brief Updates on Health Department of the Future Adopted Recommendations

Core Services (Foundational Capabilities/Areas)
Dr. Robin Ikeda, Deputy Director, Office for Non-infectious Diseases, Injury & Environmental Health, CDC, provided an update on core services. Rather than address core services recommendations in a vacuum, we thought it would be more efficient to do this by working with and being part of the RESOLVE process to explore foundational capabilities and foundational areas. This work occurred last year and early this year. RESOLVE public health leadership forum released their draft document for feedback. This was distributed this week to STLT subcommittee and is also available on the website   The Consensus report, includes a framework for governmental public health services and highlights definitions and foundational capability areas. One main driver was to determine concrete definitions for the foundational capabilities and areas and use this for cost estimation. Using cost will help build an understanding of what sustainable funding might look like for a basic set of public health services that should be available in all jurisdictions. RESOLVE welcomes comments from this committee and others as it begins to vet the document, which will evolve with time as they receive additional input. Cost estimation work for these services and areas is still underway and will be critical to finance discussions.

Shared Services
Dr. Ikeda reported that cross jurisdictional sharing options for public health services continue to grow as a viable option for achieving greater efficiency. This will lead to higher quality of public health services and in some areas, cross jurisdictional sharing has grown to be the option of choice (e.g., regional laboratory services). A website will be launched on CDC's STLT gateway that will describe the topic of cross-jurisdictional sharing and will provide examples of how CDC is encouraging cross-cutting jurisdictional sharing and then link to other external websites that have additional resources. As of this meeting, the website has been developed and is going through the CDC clearance process. It should be available in a month or two. CDC continues to partner with the Center for Sharing Public Health Services and they have developed a very impressive roadmap that articulates an interactive way how to achieve cross jurisdictional sharing. Their work will be linked from the CDC website and we will make sure that link gets out to everybody.

Community Health Needs Assessments
Dr. Laura Seeff reported that CDC is working with key stakeholders to prepare the field and primarily non-profit hospitals for the next CHNA cycle. 2015 tax year is the next time non-profit hospitals have to prepare CHNAs.

Context of the work
  ➢ The goal is to move from current state of unaligned to a unified Community Health Improvement Framework
  ➢ Process towards a CDC-developed Community Health Improvement (CHI) technical package for 2015 tax year as a unified framework to improve health outcomes and reduce health disparities
  ➢ Broadly, this will assess existing tools hospitals and communities are currently using and help to develop a common framework that addresses gaps based on existing tools

Activities
April
- Gap analysis of existing resources
- Assess uptake of CHI Guiding Principles
April-May
- Identify 20-30 Best Practice Communities, pilot test with 5-10 CHNA

Development Phase

In late 2014, CDC anticipates release of a CHI Technical Package which will include tools & resources focusing on high-burden preventable conditions, CHI Guiding Principles, CHNA.org, CHI Best Practice Community Models and other existing CHNA tools. Short-term outcomes include the dissemination of the technical package via CDC, partner organizations, and communities in early 2015. Intermediate Outcomes (2015/2016) include the following: use by communities of the technical package, completion of Community Health Needs Assessments and implementation plans (e.g., address health disparities and core high-burden preventable conditions, reflect CHI Guiding Principles, demonstrate collective impact, and CHI Best Practice Communities emerge). Long-Term Outcomes (2017 and beyond) include improved health outcomes, reduction of health disparities, communities' best practices emerge and long term outcomes.

- CDC looks to this subcommittee to participate in multiple points along the way, including dissemination. This plan has recently been shared with the Association for Community Health Improvement and as per early feedback from the field, this will fill a gap that communities and hospitals are asking for in the context of a shared framework.

  Timeline for CHI Technical packet
  - May – July: Develop draft CHI technical package
  - July – Sept.: Pilot test technical package with 5-10 communities
  - Dec. - Finalize and disseminate technical package, so ready for 2015

- Comment: This is very important for our communities and we need to look at community level data. We are partnering with NYC DOH/MH to learn more about their work with Montefiore hospital.

VII.   **Public Comment**
No public comments were made.

VIII.   **Closing**
Dr. David Fleming thanked all the CDC presenters and subcommittee members for joining the call. He reminded the group of the 3 workgroups of the STLT Subcommittee:
1. Budget/finance workgroup-- will be formed in the next few weeks
2. Surveillance/HIE/HIT/EHR workgroup – to be formed later in the summer
3. Social Determinants of Health workgroup – already formed and will hold 2nd meeting in the Spring
The meeting was then adjourned.

Certification

I hereby certify that, to the best of my knowledge and ability, the forgoing minutes of March 27, 2014 meeting of the State, Tribal, Local and Territorial workgroup are accurate and complete.

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Date   David Fleming, MD