



Council on Linkages Between Academia and Public Health Practice

Virtual Meeting

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**Wednesday, November 30, 2022
12:00-2:00pm ET**

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Zoom Meeting URL:

[https://phf-
org.zoom.us/j/87619285213?pwd=OEJtWVhialc2Q
3pOZIBGS0xCNmlZUT09](https://phf-org.zoom.us/j/87619285213?pwd=OEJtWVhialc2Q3pOZIBGS0xCNmlZUT09)

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Funding provided by the Centers for Disease Control and Prevention

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Staffed by the Public Health Foundation

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 - Council Constitution and Bylaws
 - Council Participation Agreement
 - Council Strategic Directions, 2016-2020

1. Meeting Agenda



**Council on Linkages Between Academia and Public Health Practice
Virtual Meeting**

Date: November 30, 2022

Time: 12-2pm EST

Meeting URL: <https://phf-org.zoom.us/j/87619285213?pwd=OEJtWVhialc2Q3pOZIBGS0xCNmlZUT09>

Meeting ID: 876 1928 5213

Passcode: 338717

Phone Number: (301) 715-8592

AGENDA

- | | | |
|-------------|---|--|
| 12:00-12:10 | Welcome and Overview of Agenda | <i>Bill Keck</i> |
| 12:10-12:15 | Approval of Minutes from September 29, 2022 Meeting
➤ Action Item: Vote on Approval of Minutes | <i>Bill Keck</i> |
| 12:15-12:45 | The Year in Review:
➤ Academic Health Department Learning Community (Council Strategic Directions – A.1.a., A.1.b.)
➤ Core Competencies for Public Health Professionals (Council Strategic Directions – B.1.b., C.3.a., C.3.b., C.3.c., C.3.d.) | <i>Kathleen Amos</i> |
| 12:45-1:15 | Looking Ahead: Council Contributions to Rebuilding the Public Health Workforce (Council Strategic Directions – C.1.e.) | <i>Ron Bialek</i> |
| 1:15-1:40 | Increasing Flu Vaccination: How Practice and Academia Can Help | <i>Vanessa Lamers,
Alicia Budd,
Erin Burns,
Ron Bialek</i> |
| 1:40-2:00 | Other Business and Next Steps | <i>Bill Keck</i> |
| 2:00 | Adjourn | |

2. Council Member List



Council on Linkages Members

Council Chair:

C. William Keck, MD, MPH
American Public Health Association

Council Members:

Susan Swider, PhD, APHN-BC
American Association of Colleges of Nursing

Laura Rasar King, MPH, MCHES
Council on Education for Public Health

Olabisi Badmus, MD, MPH
American College of Preventive Medicine

Health Resources and Services Administration

Amy Lee, MD, MPH, MBA
Association for Prevention Teaching and Research

Terry Brandenburg, MBA, MPH, CPH
National Association of County and City Health Officials

Gary Gilmore, MPH, PhD, MCHES
Association of Accredited Public Health Programs

Andrew J. Quarnstrom
National Association of Local Boards of Health

Leah Gillis, PhD
Association of Public Health Laboratories

Kaye Bender, PhD, RN, FAAN
National Board of Public Health Examiners

Paul K. Halverson, DrPH, FACHE
Association of Schools and Programs of Public Health

D. Gary Brown, DrPH, CIH, RS, DAAS
National Environmental Health Association

John Wiesman, DrPH, MPH
Association of State and Territorial Health Officials

National Library of Medicine

Ellen P. Averett, PhD, MHSA
Association of University Programs in Health Administration

Melissa (Moose) Alperin, EdD, MPH, MCHES
National Network of Public Health Institutes

Michelle Carvalho, MPH, MCHES
Liza Corso, MPA
Centers for Disease Control and Prevention

Rex Archer, MD, MPH
Public Health Accreditation Board

Barbara Gottlieb, MD
Community-Campus Partnerships for Health

Michael Fagen, PhD, MPH
Society for Public Health Education

Lori Edwards, DrPH, MPH, BSN, RN, CNS-PCH, BC
Council of Public Health Nursing Organizations

Nancy Harada, PhD, PT
Veterans Health Administration

Council of State and Territorial Epidemiologists

3. Draft Meeting Minutes – September 29, 2022



Council on Linkages Between Academia and Public Health Practice Virtual Meeting

Date: September 29, 2022, 12-2pm EDT

Meeting Minutes – Draft

Members and Designees Present: Linda Alexander, Ellen Averett, Terry Brandenburg, Michelle Carvalho, Marita Chilton, Liza Corso, Michael Fagen, Allison Foster, Leah Gillis, Gary Gilmore, Nancy Harada, Laura Rasar King, Amy Lee, Megan Lincoln, Lisa Sedlar, Susan Swider, John Wiesman

Other Participants Present: Jackie Abramson, Jim Adams, Mayela Arana, Rocio Arguijo, Jeanine Arrighi, Dana Baker, Mike Barry, Jennifer Beard, Emily Burke, Tom Burroughs, Cheryl Butler, E. Casso, Siobhan Champ-Blackwell, Iris Contreras, Javier Crespo, Leslie deRosset, Robert Dickinson, Tammy Dillard-Steels, Serena Draper Hendershot, Mark Edgar, Ashley Edmiston, Dory Escobar, Jocelyn Estiandan, Carrie Evans, Dena Fife, Traci Fowler, Adrienne Gill, Nolan Gill, Doris Harris, Hannah Hayes, Shelley Hoekstra, Laurencia Hutton-Rogers, Allison Jacobs, Kate, David Knapp, Kate Kollman, Tom Kollmer, Kirk Koyama, Esther Kukielka, Phoebe Kulik, Ethan Lambert, Lisa Lang, Jessie Legros, Jimena Loveluck, Helen Malcolm, Nola Martz, Jennifer McBride, Lloyd Michener, Anarris Monger, Judy Monroe, Linda Nelson, Eyal Oren, Victoria Otterman, Janet Place, Tonya Price, Maura Proser, Darren Rausch, Shelby Rentmeester, Sade Richardson, Daniel Rizik-Baer, Michael Rodriguez, Jennifer Romaszewski, Wendy Rose, Annabelle Russell, Tali Schiller, Rashmi Shetgiri, Josette Shipley, Jimmie Smith, Madisyn Smith, Matt Stefanak, Melody Stephenson, Kaitlin Tager, JT Theofilos, Karla Todd Barrett, Kathi Traugh, Sharon Trivette, Laura Valentino, Vanessa, Veronica, Alice Vestergaard, Liz Weist, Ruth Willard, Amber Williams, Mona Z., Dany Zimmel

Staff Present: Ron Bialek, Kathleen Amos, Grace Davis, Jennifer Harmon, Samantha Draper

Agenda Item	Discussion	Action
Welcome and Overview of Agenda	The meeting began with a welcome by Council Director Ron Bialek, MPP. Mr. Bialek thanked the Centers for Disease Control and Prevention (CDC) for the funding support that has enabled current Council activities, reminded participants of the Council's mission, and reviewed the agenda for the meeting.	
Approval of Minutes from June 24, 2022 Meeting	Mr. Bialek asked for any changes to the minutes of the June 24, 2022 Council meeting. Gary Gilmore, MPH, PhD, MCHES, moved to approve the minutes as written. John Wiesman, DrPH, MPH, seconded the motion. No additions or corrections.	Minutes of the June 24, 2022 Council meeting were approved as written.
Rebuilding the Public Health Workforce	Mr. Bialek led a discussion on efforts to rebuild the public health workforce. Judy Monroe, MD, President and CEO, CDC Foundation, shared perspectives from the CDC Foundation on rebuilding the workforce. Surge staffing for health departments during the COVID-19 pandemic has provided	

	<p>useful insights into effective strategies for strengthening the workforce.</p> <p>Mr. Bialek invited questions and discussion for Dr. Monroe.</p> <p>Michelle Carvalho, MPH, MCHES, CDC Council Representative and Lead, Learning Design & Fellowship Education Team, Division of Scientific Education and Professional Development, Center for Surveillance, Epidemiology, and Laboratory Services, CDC, shared the newly released Introduction to Public Health Practice training plan. The plan is available on CDC TRAIN.</p> <p>Mr. Bialek invited questions and discussion for Ms. Carvalho.</p> <p>Megan Lincoln, MSW, Public Health Analyst, Division of Nursing and Public Health, Bureau of Health Workforce, Health Resources and Services Administration, provided updates on the Regional Public Health Training Centers (PHTCs). The Bureau of Public Health Workforce is working with the PHTCs to grow leadership institutes, student placement programs, and initiatives to improve the workforce.</p> <p>Mr. Bialek invited questions and discussion for Ms. Lincoln.</p>	
<p>Academic Health Department Learning Community</p>	<p>Council Assistant Director Kathleen Amos, MLIS, provided an update on Academic Health Department (AHD) Learning Community activities.</p> <p>The AHD Learning Community is a national community that brings together and supports practitioners, educators, researchers, and others to explore AHD partnerships, share their experiences, and engage in collaborative learning. Since its launch in January 2011, the AHD Learning Community has grown to more than 1,200 members from health departments, academic institutions, and other organizations across the country. The Learning Community offers resources and activities to support AHD partnerships, including a venue for sharing examples and stories of AHD partnerships, webinars featuring AHD partnerships, examples of partnership agreements, a listserv for communication, and technical assistance.</p> <p>Thus far in 2022, the Learning Community and its resources and tools have been accessed online more than 7,000 times. This brings online usage since launch of the Learning Community to more than 83,000 visits. To date in 2022, staff have responded to 15 requests for assistance related to AHD partnerships, serving organizations in 10 states and DC.</p> <p>AHD partnerships were highlighted at the 2022 National Association of County and City Health Officials (NACCHO) 360 Conference in July in a livestreamed session: <i>Envisioning and Building the Public Health Workforce of the Future Through Partnerships</i>. AHD partnerships will also be discussed in a webinar in late October or early</p>	<p>More information about the AHD Learning Community and its activities is available through the AHD Learning</p>

	<p>November 2022 as part of the AHD Webinar Series. Additional details about the event will be shared through the Council website, AHD Learning Community, and <i>Council on Linkages Update</i>.</p> <p>Ms. Amos invited questions about the AHD Learning Community.</p>	<p>Community section of the Council website or by contacting Kathleen Amos at kamos@phf.org.</p>
<p>Core Competencies for Public Health Professionals</p>	<p>Ms. Amos provided an update on the Core Competencies for Public Health Professionals (Core Competencies).</p> <p>The Core Competencies, a set of foundational or crosscutting skills for professionals engaged in public health practice, education, and research, are used in workforce development activities across the US. The most current data show that approximately 80% of state health departments, 60% of tribal health organizations, 45% of local health departments, 25% of territorial health departments, and 90% of academic programs with a public health focus use the Core Competencies. The Core Competencies are used in a variety of ways, including to guide development of job descriptions and performance objectives, competency or training needs assessments, education and training, workforce development plans, other competency sets, and other tools and resources to support professional development for public health professionals. These competencies also appear in major national initiatives, such as Healthy People and accreditation; are integrated into the TRAIN Learning Network; and are designed to reflect the knowledge and skills needed to deliver the 10 Essential Public Health Services.</p> <p>To date in 2022, the Core Competencies and resources and tools that support implementation have been accessed online more than 72,000 times, with more than 38,000 visits to the Core Competencies and more than 34,000 visits to resources and tools. Since the latest version of the Core Competencies was released in November 2021, the webpage has been visited nearly 45,000 times. So far in 2022, Council staff have responded to 32 requests for assistance related to the Core Competencies, serving organizations in 15 states and Tanzania.</p> <p>The 2021 Core Competencies were adopted in October 2021 and have been available through the Council website since November 2021. Since that time, Council staff have been engaged in dissemination activities to try to ensure the public health community is aware of and has access to this latest version for their workforce development efforts. The Core Competencies were shared during a session at the 2022 NACCHO360 Conference in July and will be featured in several sessions at the American Public Health Association 2022 Annual Meeting & Expo in November.</p> <p>Since the release of the 2021 Core Competencies, Council staff have been working on updating and developing resources and tools that support use of the Core Competencies and help with the transition from the 2014 to</p>	

	<p>the 2021 version. Updated competency assessments are available on the Council website, and the 2021 Core Competencies have been made available on the TRAIN Learning Network as a search filter. Most recently, a competency prioritization tool that supports organizations in identifying the most important Core Competencies for different public health jobs has been updated to help organizations in determining where to focus competency development efforts. Updates of additional resources and tools are underway. As resources and tools are completed, they will be posted on the Council website and shared through the <i>Council on Linkages Update</i>.</p> <p>Ms. Amos invited questions about the Core Competencies.</p>	<p>More information about the Core Competencies can be found through the Core Competencies section of the Council website or by contacting Kathleen Amos at kamos@phf.org.</p>
<p>Core Competencies for Interprofessional Collaborative Practice</p>	<p>Mr. Bialek invited Liz Weist, MA, MPH, CPH, Director of Education, Association of Schools and Programs of Public Health, to speak about the Core Competencies for Interprofessional Collaborative Practice (IPEC Core Competencies), which are currently under revision, and how the Council can engage in the revision process. Online feedback sessions on the draft revisions will be held in early 2023.</p> <p>Mr. Bialek invited questions for Ms. Weist.</p>	<p>More information about the revisions of the IPEC Core Competencies can be found on the IPEC website.</p>
<p>Racial Justice Competency Model</p>	<p>Mr. Bialek invited Mayela Arana, MPH, CHES, CPH, Associate Director, Region 2 PHTC; Dena Fife, MA, Instructional Services Specialist, Midwestern PHTC; and Dany Zimmel, MPH, Training and Engagement Manager, Region V PHTC, to speak about the Racial Justice Competency Model for Public Health Professionals expected to be released in October. The PHTC Network, a consortium of 10 PHTCs, has worked to develop a competency set in response to recent events addressing racial and health equity. The competencies will be available to download from rjcmph.org on October 1, 2022.</p> <p>Mr. Bialek invited questions for Ms. Arana, Ms. Fife, and Ms. Zimmel.</p>	<p>More information about the Racial Justice Competency Model for Public Health Professionals will be available on the Racial Justice Competencies for Public Health Professionals website.</p>
<p>CDC E-Learning Institute Fellowship Program</p>	<p>Mr. Bialek invited Ms. Carvalho to share information about CDC’s E-Learning Institute Fellowship Program (ELI), which is currently accepting applications. ELI is a program designed for public health professionals with limited experience developing e-learning materials, providing support from experts who serve as mentors for participants. Applications are open until October 21, 2022.</p> <p>Mr. Bialek invited questions for Ms. Carvalho.</p>	<p>More information about ELI and how to apply is available on the ELI website.</p>
<p>Other Business and Next Steps</p>	<p>Mr. Bialek asked if there was any other business to address.</p> <p>The next Council meeting will take place on November 30, 2022.</p>	<p>Questions can be sent to Kathleen Amos at kamos@phf.org.</p>

4. The Year in Review:

- **Academic Health Department Learning Community**
- **Core Competencies for Public Health Professionals**



The Year in Review

November 30, 2022

Overview

Throughout its 30-year history, the [Council on Linkages Between Academia and Public Health Practice](#) (Council) has focused on building and strengthening public health infrastructure. The Council brings together public health practice and academia to advance workforce development for the public health and population health workforce. Current Council initiatives focus in two main areas: the [Academic Health Department \(AHD\) Learning Community](#) and the [Core Competencies for Public Health Professionals](#) (Core Competencies).

Academic Health Department Learning Community

The [AHD Learning Community](#) supports development of [AHD partnerships](#) between public health practice organizations and academic institutions. As a national community of practitioners, educators, and researchers, the AHD Learning Community stimulates discussion and sharing of knowledge; the development of resources; and collaborative learning around establishing, sustaining, and expanding AHD partnerships.

Throughout the year, the AHD Learning Community was involved in a variety of activities, including engaging in webinars and conference presentations, providing technical assistance, and developing and disseminating related communications. The following summary details activities and accomplishments for 2022.

Engagement with the AHD Learning Community

- The AHD Learning Community continued to grow and now includes approximately 1,500 members.
- To date in 2022, the Learning Community and its resources and tools have been accessed more than 8,500 times. This brings online usage of the Learning Community and its tools and resources to more than 84,000 visits since its launch in 2011.
- AHD partnerships continued to be added to the [list of AHD partnerships](#) on the Council website, as part of an ongoing effort to raise awareness of AHD initiatives nationwide, bringing the total number of documented partnerships to more than 100. Additional partnerships or [examples of partnership agreements](#) to be included in the online resources may be shared with Kathleen Amos at kamos@phf.org.
- Council staff responded to more than 15 requests for distance technical assistance related to AHD partnerships, serving 14 organizations in 12 states and DC.

Webinars and Conferences

- The AHD Learning Community continued to offer the [AHD Webinar Series](#), which highlights successful AHD partnerships and other topics of interest for developing, sustaining, and expanding AHD partnerships. Two webinars were held and were attended by nearly 500 participants:
 - February – [Envisioning and Building the Public Health Workforce of the Future: The Critical Role of Partnerships](#)
 - November – [Ask Me Anything – Academic Health Department Partnerships](#)
- [AHD Webinar Series](#) events are recorded and made available through the [Council website](#), [TRAIN Learning Network](#), and [YouTube](#) for continued access.

- AHD partnerships were highlighted during a webinar hosted by the American Association of Colleges of Nursing in April: [Partnerships Between Academic Health Departments and Schools of Nursing](#). This webinar was archived and is available on the [AACN website](#).
- AHD partnerships were also featured in four sessions at conferences:
 - May – Missoula Academic Health Department Conference virtual session: *Academic Health Department Partnerships*
 - June – [2022 Public Health Improvement Training \(PHIT\) virtual session](#): *Envisioning and Building the Public Health Workforce of the Future: The Value of Partnerships*
 - July – [2022 National Association of County and City Health Officials \(NACCHO\) 360 Conference](#) virtual livestream session: *Envisioning and Building the Public Health Workforce of the Future Through Partnerships*
 - November – American Public Health Association (APHA) 2022 Annual Meeting & Expo session: [Strengthening the Public Health Workforce: The Role of the Council on Linkages Between Academia and Public Health Practice](#)

More information about AHD Learning Community activities is available through the [AHD Learning Community](#) section of the Council website or by contacting Kathleen Amos at kamos@phf.org.

Core Competencies for Public Health Professionals

The [Core Competencies for Public Health Professionals](#) (Core Competencies) reflect foundational or crosscutting knowledge and skills for professionals engaged in the practice, education, and research of public health. Guidance for Council efforts related to the Core Competencies is provided by the [Core Competencies Workgroup](#), which includes approximately 120 members representing a variety of practice and academic organizations and interests within the public health field. The Core Competencies were recently revised, with the current version completed in October 2021.

Activities supporting implementation of the Core Competencies continued in 2022, with sustained usage of the Core Competencies and tools, training, and technical assistance being provided. The following summary details activities and accomplishments for 2022.

Engagement with the Core Competencies

- To date in 2022, the Core Competencies and resources and tools designed to support implementation have been accessed online more than 88,000 times, with more than 53,000 visits to the [Core Competencies webpage](#) since the 2021 version was released.
- Council staff responded to more than 40 technical assistance requests, serving 30 organizations in 17 states, DC, and Tanzania.
- Council staff participated in working groups supporting the development of the [Racial Justice Competencies for Public Health Professionals](#) by the Public Health Training Centers (PHTCs) and updating of the [Applied Epidemiology Competencies](#) by the Council of State and Territorial Epidemiologists.
- The Core Competencies were highlighted in the October [New to Public Health Residency Program: Building Core Competencies for Public Health Practice](#) post by the University of Wisconsin-Madison School of Nursing on the PHF Pulse blog.

Resources and Tools Related to the Core Competencies

- Updated versions of the [competency assessments](#) were created based on the 2021 Core Competencies. Four competency assessment instruments are available – one that

includes only the competency statements in the Core Competencies and one for each of the three tiers in the Core Competencies.

- The 2021 Core Competencies were made available as a search filter on the [TRAIN Learning Network](#), allowing course providers to indicate which competencies their trainings address and learners to search for trainings that build specific competencies.
- A [prioritization tool](#) that supports organizations in identifying the most essential Core Competencies for different jobs within public health was updated with the 2021 Core Competencies. Facilitation materials for conducting a workshop-based voting process to prioritize Core Competencies are provided.

Webinars and Conferences

- The Core Competencies were featured at four webinars or virtual meetings, attended by more than 1,200 participants:
 - February – Region 2 PHTC Log-in2Learn Webinar: [Introducing the 2021 Core Competencies for Public Health Professionals](#)
 - March – [Introducing the 2021 Core Competencies for Public Health Professionals](#)
 - March – Network of the National Library of Medicine’s Public Health Collaborative meeting: *Introducing the 2021 Core Competencies for Public Health Professionals*
 - March – National Indian Health Board’s Tribal Accreditation Learning Community Webinar Series: *Introducing the 2021 Core Competencies for Public Health Professionals*
- The Core Competencies were also highlighted during seven conference sessions:
 - January – [2022 Open Forum: Next Generation](#) virtual session: *Introducing the 2021 Core Competencies for Public Health Professionals: Crosscutting Skills for a High-Performing Workforce*
 - June – [2022 PHIT](#) virtual sessions:
 - *Building a Strong Workforce Development Program*
 - *Who Has Time for Workforce Development? Reinvigorating Your Workforce Development Program*
 - July – [2022 NACCHO360 Conference](#) on demand session: *Introducing the 2021 Core Competencies for Public Health Professionals: Crosscutting Skills for a High-Performing Workforce*
 - November – [APHA 2022 Annual Meeting & Expo](#) sessions:
 - [Strengthening the Public Health Workforce: The Role of the Council on Linkages Between Academia and Public Health Practice](#)
 - *New Tools for Using the 2021 Core Competencies for Public Health Professionals*
 - *Advancing Health Equity with the Core Competencies for Public Health Professionals*

More information about activities related to the Core Competencies is available through the [Core Competencies](#) section of the Council website or by contacting Kathleen Amos at kamos@phf.org.

5. Looking Ahead: Council Contributions to Rebuilding the Public Health Workforce



Looking Ahead: Council Contributions to Rebuilding the Public Health Workforce

November 30, 2022

Overview

For 30 years, the [Council on Linkages Between Academia and Public Health Practice](#) (Council) has been providing support for the US public health workforce and advancing workforce development efforts nationwide. This has included early work to lay the groundwork for [The Community Guide](#) (The Guide to Community Preventive Services) and the field of public health services and systems research (PHSSR), contributions to [Council on Education for Public Health](#) accreditation for schools and programs of public health and [Public Health Accreditation Board](#) accreditation for health departments, development of [foundational competencies](#) for the practice and teaching of public health, and strengthening [partnerships](#) and collaboration between public health practice and academia. Over this history, the Council has grown from nine member organizations to 24, expanding its breadth and bringing in a range of partners whose efforts align in the goal of improving the public's health.

Much has happened in the world of public health since adoption of the Council's [Strategic Directions](#) in 2016. Most recently, as demonstrated throughout the COVID-19 pandemic, support for this workforce has been insufficient, jeopardizing the ability of governmental public health agencies to protect and promote the public's health. The public health workforce is critical for ensuring the health of the population, requiring action to revitalize and strengthen the workforce.

Considerable progress has been made by the Council in addressing its *Strategic Directions*. Of particular note are the adoption of revised [Core Competencies for Public Health Professionals](#) (Core Competencies) in 2021; continued expansion of resources and guidance to help establish and strengthen academic/practice partnerships; and important dialogue and sharing of lessons learned to address revitalizing and strengthening the public health workforce.

With nearly \$4 billion being allocated by the [Centers for Disease Control and Prevention](#) to governmental public health agencies focused on workforce development, the time has never been better to build the workforce needed to protect and promote health. Input from the public health community is needed to guide future directions of the Council. How can the Core Competencies best strengthen the workforce? How can health department capacity be further enhanced through the [Academic Health Department Learning Community](#)? What other areas are important for the Council to address and take action?

During this Council meeting, discussion about future directions of the Council will occur as an initial step in laying the groundwork for updating the Council's *Strategic Directions* in 2023.

6. Increasing Flu Vaccination: How Practice and Academia Can Help



Increasing Flu Vaccination: How Practice and Academia Can Help

November 30, 2022

Overview

Seasonal flu activity is high across the US. Getting vaccinated each year is the best way to reduce the risk of flu and its complications. During this meeting, Alicia Budd, MPH, Epidemiologist, and Erin Burns, MA, Associate Director for Communications, Influenza Division, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, will share updates and discuss how public health practice and academia can help increase flu vaccination. The November 18, 2022 *FluView: A Weekly Influenza Surveillance Report Prepared by the Influenza Division* is included in the meeting materials for reference.

FLUVIEW



A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Key Updates for Week 45, ending November 12, 2022

Seasonal influenza activity is elevated across the country.

Viruses

Clinical Lab

14.7%
positive for influenza
this week

Public Health Lab

The most frequently
reported viruses this week
were influenza A(H3N2).

Virus Characterization

Genetic and antigenic
characterization are
summarized in this report.

Illness

Outpatient Respiratory Illness

5.8%
of visits to a health care
provider this week were for
respiratory illness
(**above baseline**).

Outpatient Respiratory Illness: Activity Map

6 moderate jurisdictions
30 high or very high
jurisdictions

Long-term Care Facilities

1.2%
of facilities reported
≥ 1 influenza-positive test
among residents this week.

Severe Disease

FluSurv-NET

8.1 per 100,000
cumulative hospitalization rate

HHS Protect Hospitalizations

8,707
patients admitted to hospitals with influenza
this week

NCHS Mortality

9.4%
of deaths attributed to pneumonia, influenza,
or COVID-19 this week (**above threshold**)

Pediatric Deaths

2
deaths were reported this week for a total of
7 so far this season.

All data are preliminary and may change as more reports are received.

A description of the CDC influenza surveillance system, including methodology and detailed descriptions of each data component, is available on the [surveillance methods](#) page. Additional information on the current and previous influenza seasons for each surveillance component are available on [FluView Interactive](#).

Key Points

- Seasonal influenza activity is elevated across the country.
- The majority of influenza viruses detected this season have been influenza A(H3N2) viruses, but the proportion of subtyped influenza A viruses that are A(H1N1) is increasing slightly.
- Two influenza-associated pediatric deaths were reported this week.
- CDC estimates that, so far this season, there have been at least 4.4 million illnesses, 38,000 hospitalizations, and 2,100 deaths from flu.
- The cumulative hospitalization rate in the FluSurv-NET system is higher than the rate observed in week 45 during every previous season since 2010-2011.
- The majority of influenza viruses tested are in the same genetic subclade as and antigenically similar to the influenza strains included in this season's influenza vaccine.
- An annual flu vaccine is the best way to protect against flu. Vaccination helps prevent infection and can also prevent serious outcomes in people who get vaccinated but still get sick with flu.
- CDC recommends that everyone ages 6 months and older get a flu vaccine annually.
- There are also prescription flu antiviral drugs that can be used to treat flu illness; those need to be started as early as possible.

Virologic Surveillance

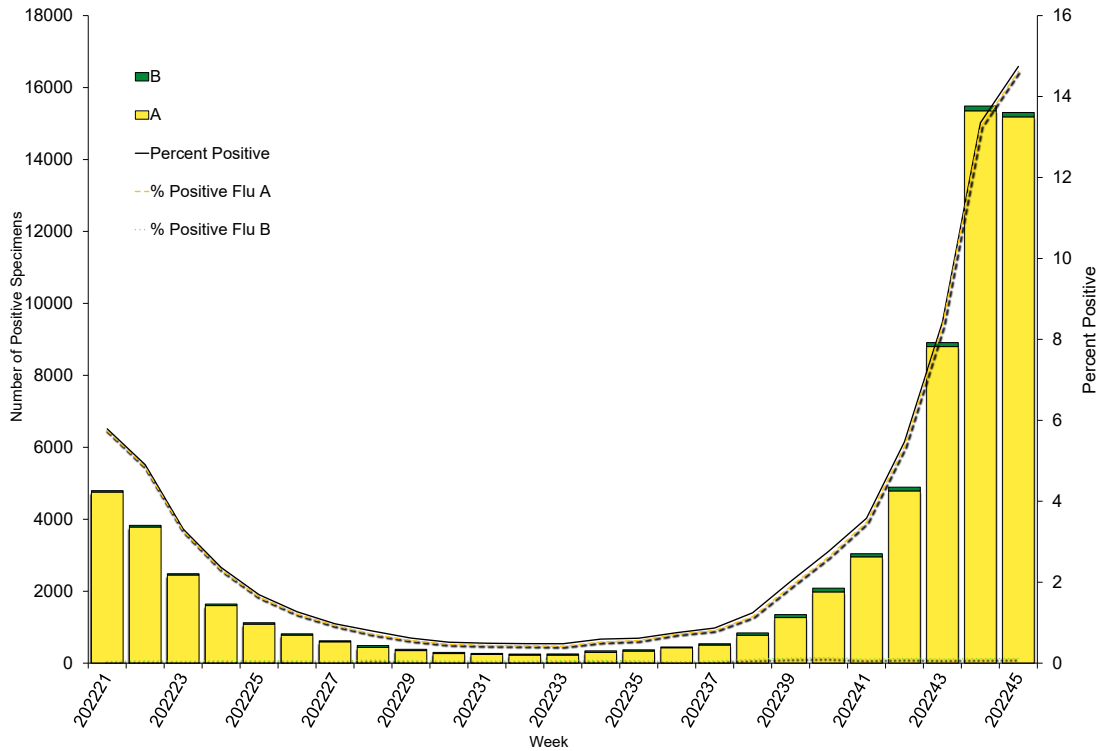
Nationally, the percentage of specimens testing positive for influenza in clinical laboratories is increasing. Percent positivity increased ≥ 0.5 percentage points this week in regions 1, 2, 3, 5, 7, 8, and 10. The majority of viruses detected so far this season have been influenza A(H3N2), however during the past three week, approximately 26% of the subtyped influenza A viruses have been influenza A(H1N1) viruses. For regional and state level data and age group distribution, please visit [FluView Interactive](#). Viruses known to be associated with recent live attenuated influenza vaccine (LAIV) receipt or found upon further testing to be a vaccine virus are not included, as they are not circulating influenza viruses.

Clinical Laboratories

The results of tests performed by clinical laboratories nationwide are summarized below. Data from clinical laboratories (the percentage of specimens tested that are positive for influenza) are used to monitor whether influenza activity is increasing or decreasing.

	Week 45	Data Cumulative since October 2, 2022 (Week 40)
No. of specimens tested	103,830	575,479
No. of positive specimens (%)	15,308 (14.7%)	49,726 (8.6%)
<i>Positive specimens by type</i>		
Influenza A	15,185 (99.2%)	49,064 (98.7%)
Influenza B	123 (0.8%)	662 (1.3%)

**Influenza Positive Tests Reported to CDC by U.S. Clinical Laboratories,
National Summary, May 22, 2022 – November 12, 2022**

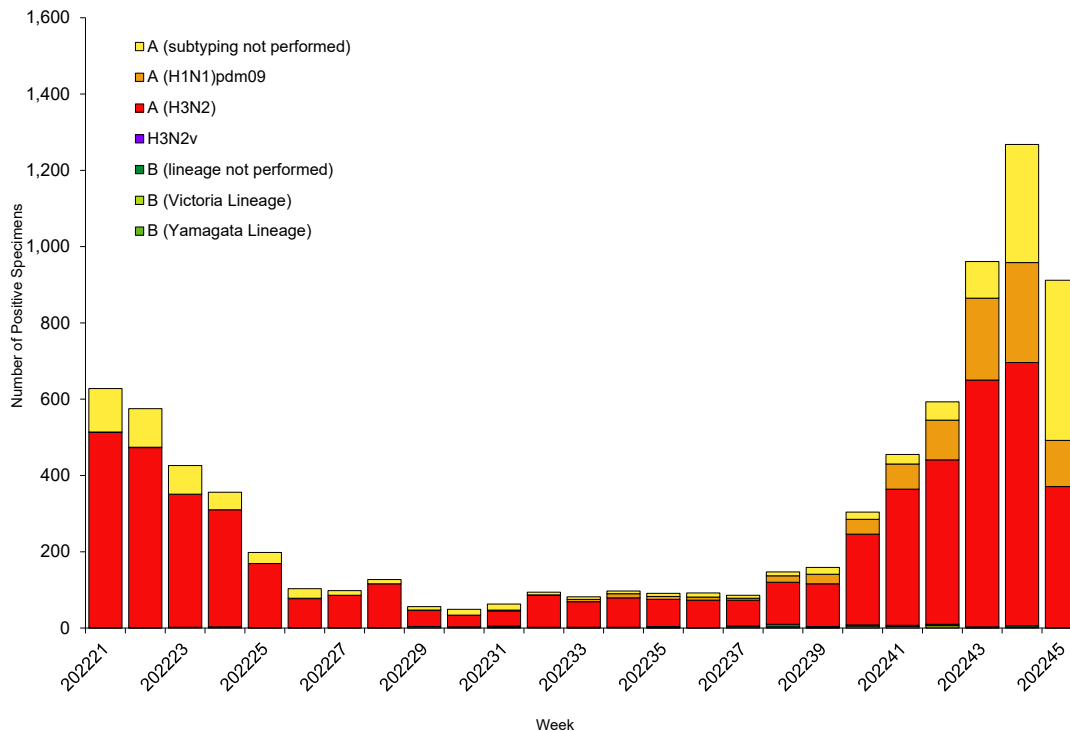


Public Health Laboratories

The results of tests performed by public health laboratories nationwide are summarized below. Data from public health laboratories are used to monitor the proportion of circulating viruses that belong to each influenza subtype/lineage.

	Week 45	Data Cumulative since October 2, 2022 (Week 40)
No. of specimens tested	7,575	53,659
No. of positive specimens	912	4,493
Positive specimens by type/subtype		
Influenza A	911 (99.9%)	4,459 (99.2%)
(H1N1)pdm09	121 (24.6%)	807 (22.8%)
H3N2	370 (75.4%)	2,733 (77.2%)
H3N2v	0	1 (<0.1%)
Subtyping not performed	420	918
Influenza B	1 (0.1%)	34 (0.8%)
Yamagata lineage	0	0
Victoria lineage	0	18 (100%)
Lineage not performed	1	16

Influenza Positive Tests Reported to CDC by U.S. Public Health Laboratories, National Summary, May 22, 2022 – November 12, 2022



Additional virologic surveillance information for current and past seasons:
[Surveillance Methods](#) | FluView Interactive: [National, Regional, and State Data](#) or [Age Data](#)

Influenza Virus Characterization

CDC performs [genetic](#) and [antigenic](#) characterization of U.S. viruses submitted from state and local public health laboratories according to the Right Size Roadmap submission guidance. These data are used to compare how similar the currently circulating influenza viruses are to the reference viruses representing viruses contained in the current influenza vaccines. The data are also used to monitor evolutionary changes that continually occur in influenza viruses circulating in humans.

CDC genetically characterized 589 influenza viruses collected since May 1, 2022.

Virus Subtype or Lineage	Genetic Characterization				
	Total No. of Subtype/Lineage Tested	HA Clade	Number (% of subtype/lineage tested)	HA Subclade	Number (% of subtype/lineage tested)
A/H1	74				
		6B.1A	74 (100%)	5a.1	5 (6.8%)
				5a.2	69 (93.2%)
A/H3	510				
		3C.2a1b	510 (100%)	1a	0
				1b	0
				2a	0
				2a.1	0
				2a.2	510 (100%)
		3C.3a	0	3a	0
B/Victoria	5				
		V1A	5 (100%)	V1A	0
				V1A.1	0
				V1A.3	0
				V1A.3a	0
				V1A.3a.1	0
				V1A.3a.2	5 (100%)
B/Yamagata	0				
		Y3	0		

CDC [antigenically characterizes](#) influenza viruses by [hemagglutination inhibition \(HI\)](#) (H1N1pdm09, B/Victoria, and B/Yamagata viruses) or neutralization-based [HINT](#) (H3N2 viruses) using antisera that ferrets make after being infected with reference viruses representing the 2022-2023 Northern Hemisphere recommended egg-based and cell- or recombinant-based vaccine viruses. Antigenic differences between viruses are determined by comparing how well the antibodies made against the vaccine reference viruses recognize the circulating viruses that have been grown in cell culture. Ferret antisera are useful because antibodies raised against a particular virus can often recognize small changes in the surface proteins of other viruses. In HI assays, viruses with similar antigenic properties have antibody titer differences of less than or equal to 4-fold when compared to the reference (vaccine) virus. In HINT, viruses with similar antigenic properties have antibody neutralization titer differences of less than 8-fold. Viruses selected for antigenic characterization are a subset representing the genetic changes in the surface proteins seen in genetically characterized viruses.

Influenza A Viruses

- **A (H1N1)pdm09:** Thirty-three A(H1N1)pdm09 viruses were antigenically characterized by HI, and 31 (94%) were well recognized (reacting at titers that were within 4-fold of the homologous virus titer) by ferret antisera to cell-grown A/Wisconsin/588/2019-like reference viruses representing the A(H1N1)pdm09 component for the cell- and recombinant-based influenza vaccines and 31 (94%) were well recognized by ferret antisera to egg-grown A/Victoria/2570/2019-like reference viruses representing the A(H1N1)pdm09 component for the egg-based influenza vaccines.
- **A (H3N2):** Fifty A(H3N2) viruses were antigenically characterized by HINT; all were well-recognized (reacting at titers that were within 8-fold of the homologous virus titer) by ferret antisera to cell-grown A/Darwin/6/2021-like reference viruses representing the A(H3N2) component for the cell- and recombinant-based influenza vaccines and 48 (96%) were well-recognized by ferret antisera to egg-grown A/Darwin/9/2021-like reference viruses representing the A(H3N2) component for egg-based influenza vaccines.

Influenza B Viruses

- **B/Victoria:** One influenza B/Victoria-lineage virus was antigenically characterized by HI; it was well recognized (reacting at titers that were within 4-fold of the homologous virus titer) by ferret antisera to cell-grown B/Austria/1359417/2021-like reference viruses representing the B/Victoria component for the cell- and recombinant-based influenza vaccines and by ferret antisera to egg-grown B/Austria/1359417/2021-like reference viruses representing the B/Victoria component for the egg-based influenza vaccines.
- **B/Yamagata:** No influenza B/Yamagata-lineage viruses were available for antigenic characterization.

CDC also tests susceptibility of circulating influenza viruses to antiviral medications including the neuraminidase inhibitors (oseltamivir, zanamivir, and peramivir) and the PA endonuclease inhibitor baloxavir. Virus antiviral susceptibility data will be reported later this season when a sufficient number of specimens have been tested.

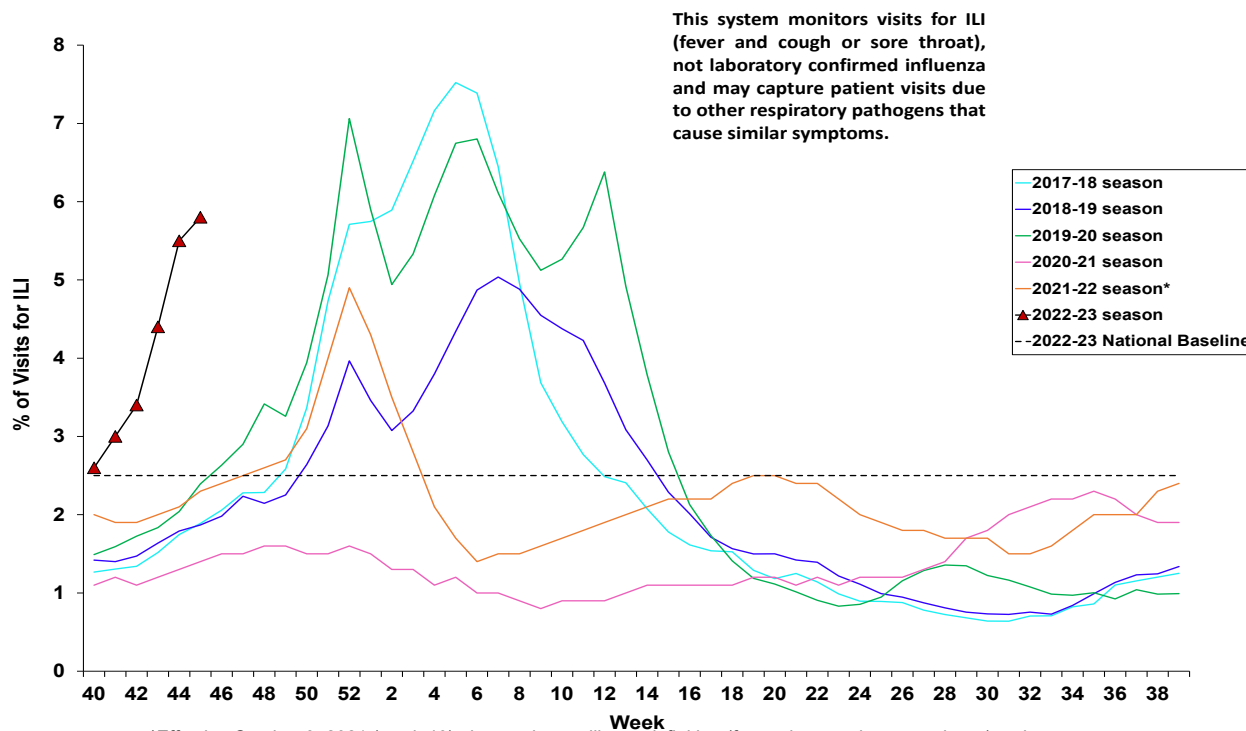
Outpatient Respiratory Illness Surveillance

The U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) monitors outpatient visits for respiratory illness referred to as influenza-like illness [ILI (fever plus cough or sore throat)], not laboratory-confirmed influenza, and will therefore capture respiratory illness visits due to infection with any pathogen that can present with similar symptoms, including influenza, SARS-CoV-2, and RSV. Due to the COVID-19 pandemic, health care-seeking behaviors have changed, and people may be accessing the health care system in alternative settings not captured as a part of ILINet or at a different point in their illness than they might have before the pandemic. Therefore, it is important to evaluate syndromic surveillance data, including that from ILINet, in the context of other sources of surveillance data to obtain a complete and accurate picture of influenza, SARS-CoV-2, and other respiratory virus activity. CDC is tracking the COVID-19 pandemic in a weekly publication called [COVID Data Tracker Weekly Review](#). Information about other respiratory virus activity can be found on [CDC's National Respiratory and Enteric Virus Surveillance System \(NREVSS\) website](#).

Outpatient Respiratory Illness Visits

Nationwide during week 45, 5.8% of patient visits reported through ILINet were due to respiratory illness that included fever plus a cough or sore throat, also referred to as ILI. This is above the national baseline of 2.5%. All 10 HHS regions are above their respective baselines. Multiple respiratory viruses are co-circulating, and the relative contribution of influenza virus infection to ILI varies by location.

Percentage of Outpatient Visits for Respiratory Illness Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Weekly National Summary, 2022-2023* and Selected Previous Seasons



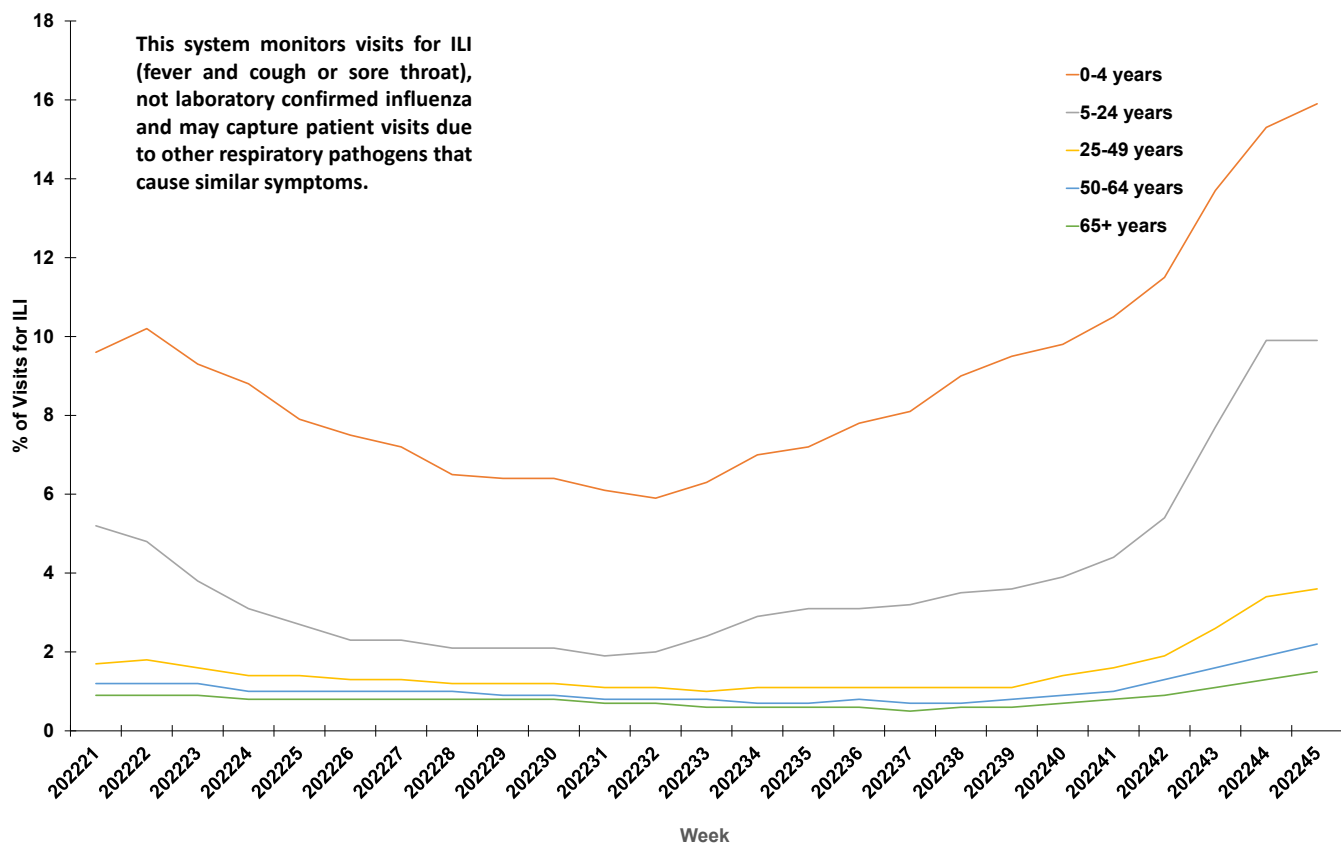
*Effective October 3, 2021 (week 40), the respiratory illness definition (fever plus cough or sore throat) no longer includes "without a known cause other than influenza."

Outpatient Respiratory Illness Visits by Age Group

More than 70% of ILINet participants provide both the number of patient visits for respiratory illness and the total number of patient visits for the week broken out by age group. Data from this subset of providers are used to calculate the percentages of patient visits for respiratory illness by age group.

The percentage of visits for respiratory illness reported in ILINet is increasing in the 0-4 years, 25-49 years, 50-64 years, and 65+ years age groups, while remaining stable in the 5-24 years age group.

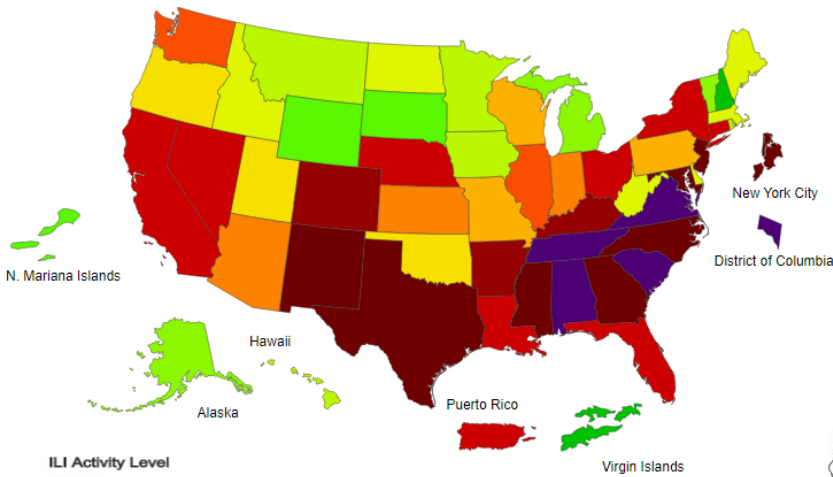
Percentage of Outpatient Visits for Respiratory Illness by Age Group Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Weekly National Summary, May 22, 2022 – November 12, 2022



Outpatient Respiratory Illness Activity Map

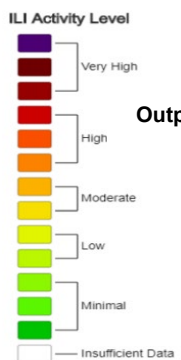
Data collected in ILINet are used to produce a measure of [ILI activity*](#) by state/jurisdiction and Core Based Statistical Areas (CBSA).

Activity Level	Number of Jurisdictions		Number of CBSAs	
	Week 45 (Week ending Nov. 12, 2022)	Week 44 (Week ending Nov. 5, 2022)	Week 45 (Week ending Nov. 12, 2022)	Week 44 (Week ending Nov. 5, 2022)
Very High	16	16	66	74
High	14	9	150	132
Moderate	6	7	101	94
Low	11	7	139	134
Minimal	8	16	225	262
Insufficient Data	0	0	248	233

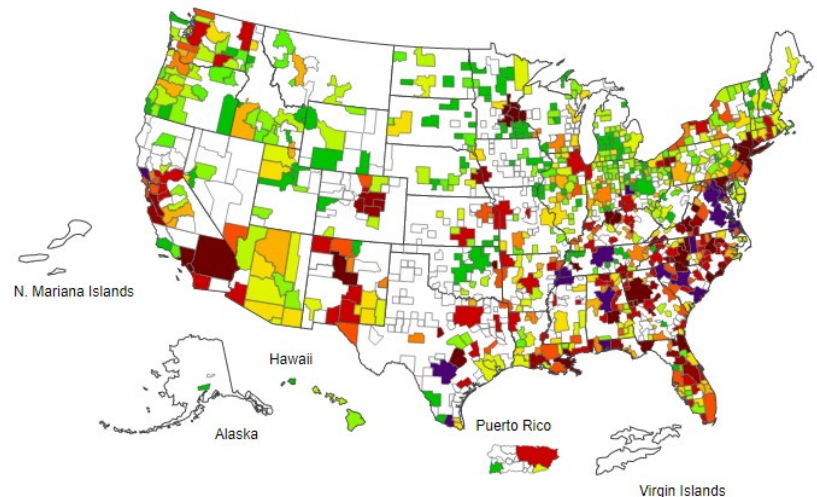


Outpatient Respiratory Illness Activity by Jurisdiction
Week 45, ending November 15, 2022

This system monitors visits for ILI (fever and cough or sore throat), not laboratory confirmed influenza and may capture patient visits due to other respiratory pathogens that cause similar symptoms.



Outpatient Respiratory Illness Activity by CBSA
Week 45, ending November 12, 2022



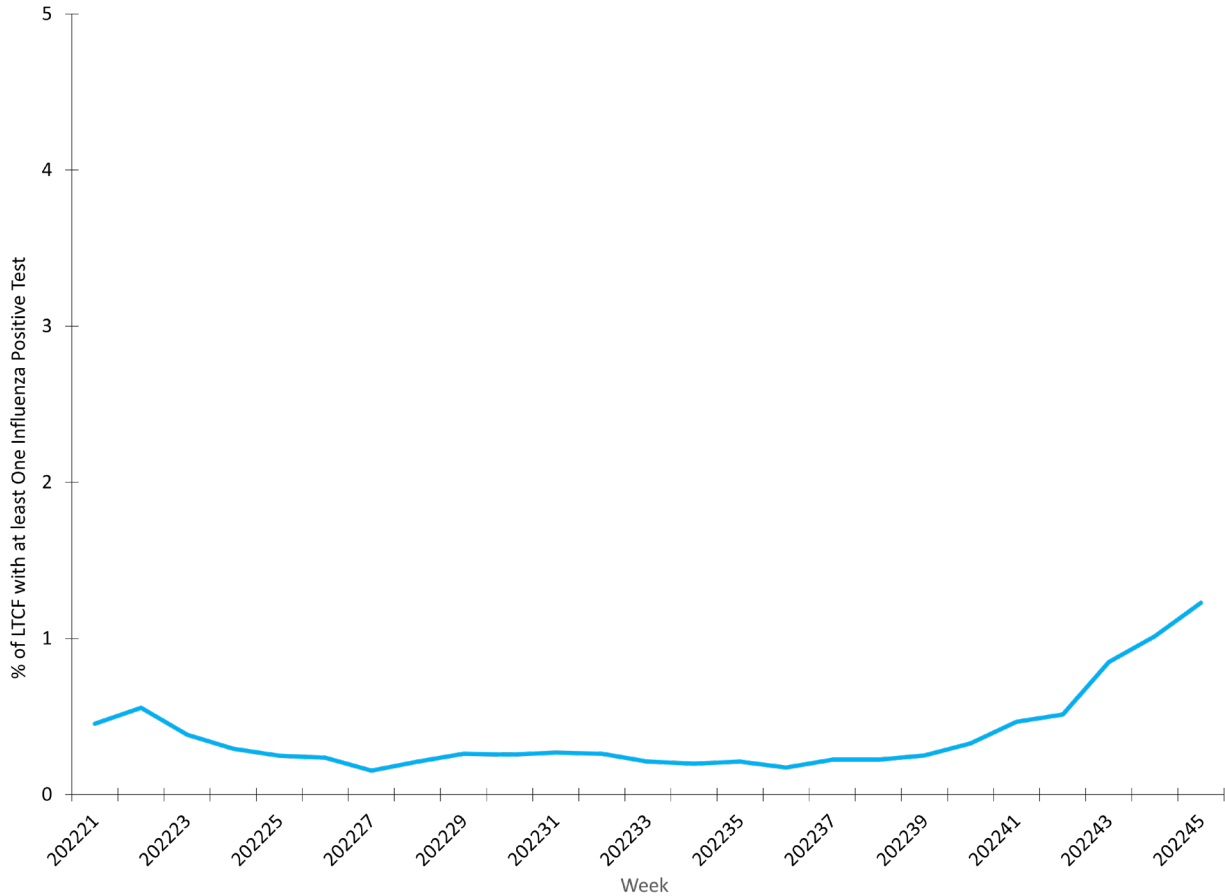
*Data collected in ILINet may disproportionately represent certain populations within a jurisdiction or CBSA, and therefore, may not accurately depict the full picture of influenza activity for the entire jurisdiction or CBSA. Differences in the data presented here by CDC and independently by some health departments likely represent differing levels of data completeness with data presented by the health department likely being the more complete.

Additional information about medically attended visits for ILI for current and past seasons:
[Surveillance Methods](#) | FluView Interactive: [National, Regional, and State Data](#) or [ILI Activity Map](#)

Long-term Care Facility (LTCF) Surveillance

LTCFs (e.g., nursing homes/skilled nursing, long-term care for the developmentally disabled, and assisted living facilities) from all 50 states and U.S. territories report data on influenza virus infections among residents through the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility Component](#). During week 45, 174 (1.2%) of 14,161 reporting LTCFs reported at least one influenza positive test among their residents.

Percent of Long-term Care Facilities (LTCF) with at Least One Confirmed Influenza Positive Test among Residents, Reported to the National Healthcare Safety Network (NHSN), National Summary, May 23, 2022 – November 13, 2022



Additional information about long-term care facility surveillance:

[Surveillance Methods](#) | [Additional Data](#)

Hospitalization Surveillance

FluSurv-NET

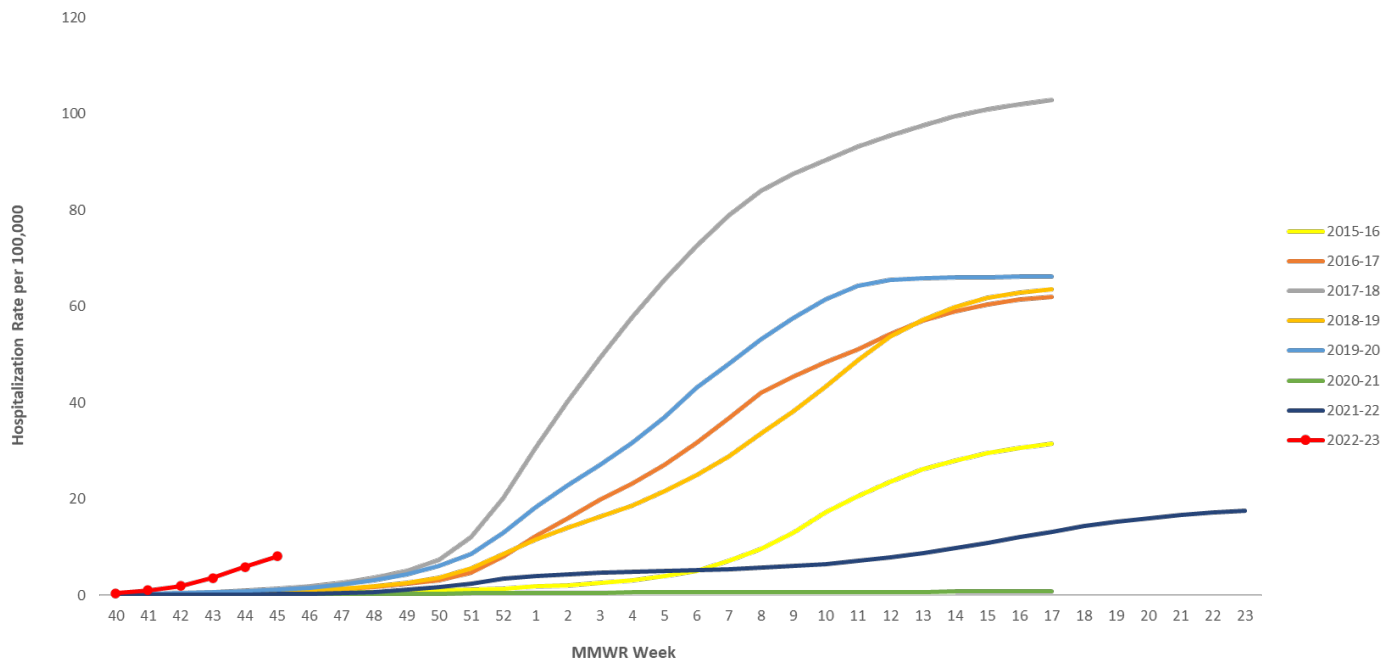
The Influenza Hospitalization Surveillance Network (FluSurv-NET) conducts population-based surveillance for laboratory-confirmed influenza-related hospitalizations in select counties in 13 states and represents approximately 9% of the U.S. population. FluSurv-NET hospitalization data are preliminary. As data are received each week, prior case counts and rates are updated accordingly.

A total of 2,370 laboratory-confirmed influenza-associated hospitalizations were reported by FluSurv-NET sites between October 1, 2022, and November 12, 2022; 95.6% were associated with influenza A virus, 2.4% were associated with influenza B virus, 0.3% with influenza A virus and influenza B virus co-infection, and 1.6% with influenza virus for which the type was not determined. Among 317 hospitalizations with influenza A subtype information, 23.3% were A(H1N1)pdm09 virus and 76.7% were A(H3N2).

The overall cumulative hospitalization rate per 100,000 population was 8.1. This cumulative hospitalization rate is higher than the cumulative in-season hospitalization rate observed in week 45 during previous seasons going back to 2010-2011, which ranged from 0.1 to 0.9. The highest hospitalization rates per 100,000 population were among adults aged ≥ 65 years (18.6), followed by children aged 0-4 years (13.6), adults aged 50-64 (8.0), children aged 5-17 years (7.3), and adults aged 18-49 years (4.2).

Cumulative hospitalization rates for each age group were higher than cumulative in-season hospitalization rates previously observed during week 45; since 2010-11 in-season rates ranged from 0 to 1.6 among children 0-4 years, 0 to 0.5 among children 5-17 years, 0 to 0.4 among adults 18-49 years, 0.1 to 0.9 among adults 50-64 years, and 0.3 to 2.7 among adults ≥ 65 years.

**Cumulative Rate of Laboratory-Confirmed Influenza Hospitalizations
among cases of all ages, 2015-16 to 2022-23, MMWR Week 45**



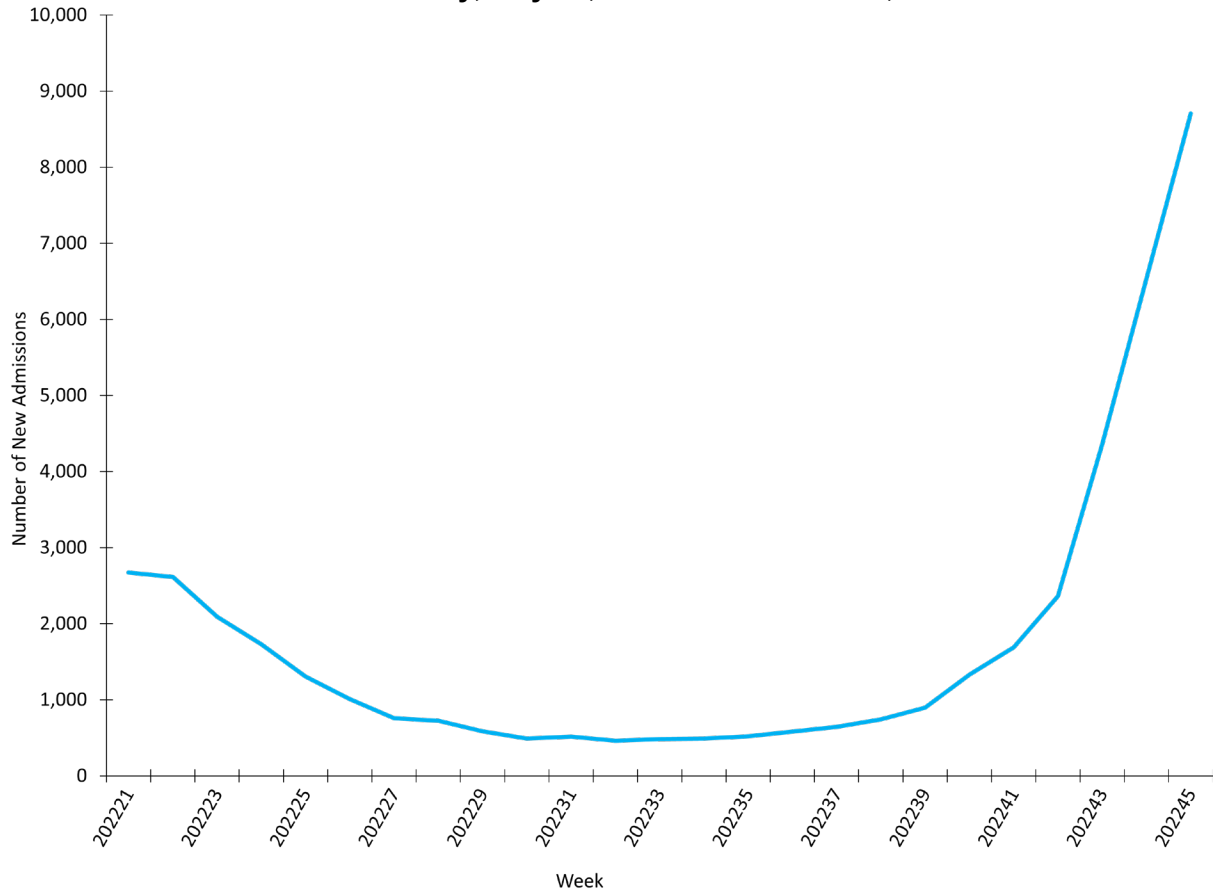
**In this figure, cumulative rates for all seasons prior to the 2022-23 season reflect end-of-season rates. For the 2022-23 season, rates for recent hospital admissions are subject to reporting delays. As hospitalization data are received each week, prior case counts and rates are updated accordingly.

Additional FluSurv-NET information for current and past seasons:
[Surveillance Methods](#) | [FluView Interactive: Rates by Age, Sex, and Race/Ethnicity](#)

HHS Protect Hospitalization Surveillance

Hospitals report to HHS Protect the number of patients admitted with laboratory-confirmed influenza. During week 45, 8,707 patients with laboratory-confirmed influenza were admitted to a hospital.

New Influenza Hospital Admissions Reported to HHS Protect, National Summary, May 22, 2022 – November 12, 2022



Additional HHS Protect hospitalization surveillance information:

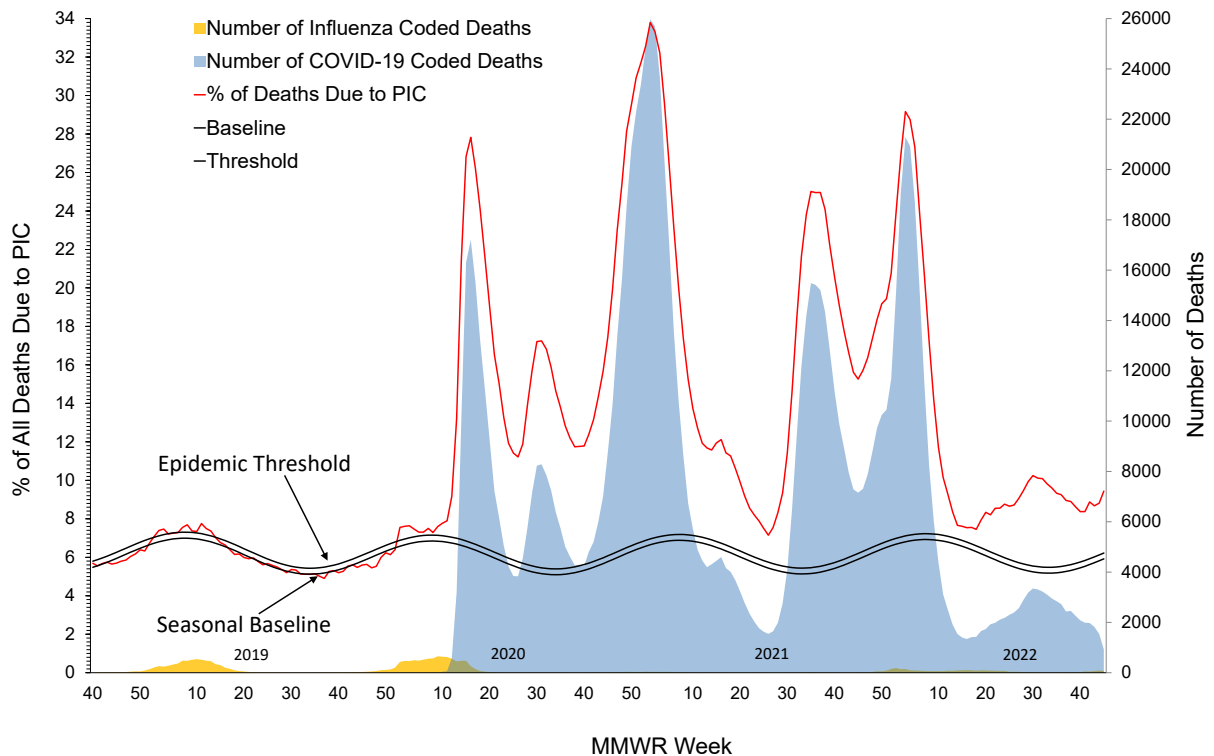
[Surveillance Methods](#) | [Additional Data](#)

Mortality Surveillance

National Center for Health Statistics (NCHS)

Based on NCHS mortality surveillance data available on November 17, 2022, 9.4% of the deaths that occurred during the week ending November 12, 2022 (week 45), were due to pneumonia, influenza, and/or COVID-19 (PIC). This percentage is above the epidemic threshold of 6.2% for this week. Among the 2,175 PIC deaths reported for this week, 926 had COVID-19 listed as an underlying or contributing cause of death on the death certificate, and 70 listed influenza. While current PIC mortality is due primarily to COVID-19, the proportion due to influenza remains small but is increasing. The data presented are preliminary and may change as more data are received and processed.

Pneumonia, Influenza, and COVID-19 Mortality from the National Center for Health Statistics Mortality Surveillance System Data as of November 17, 2022



Additional pneumonia, influenza, and COVID-19 mortality surveillance information for current and past seasons:

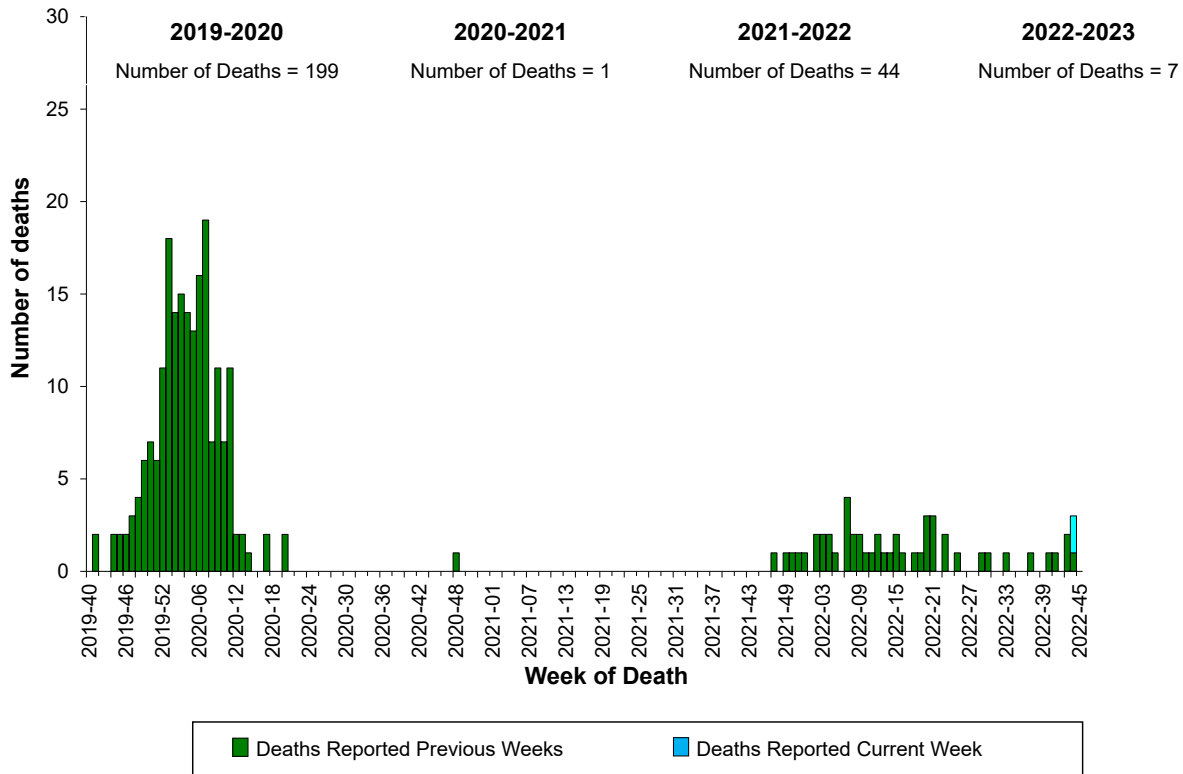
[Surveillance Methods](#) | [FluView Interactive](#)

Influenza-Associated Pediatric Mortality

Two influenza-associated pediatric deaths occurring during the 2022-2023 season were reported to CDC during week 45. One death was associated with an influenza A(H1N1)pdm09 virus and one death was associated with an influenza A(H3) virus. Both deaths occurred during week 44 (the week ending November 5, 2022).

A total of seven influenza-associated pediatric deaths occurring during the 2022-2023 season have been reported to CDC.

Number of Influenza-Associated Pediatric Deaths by Week of Death, 2019-2020 season to 2022-2023 season



Additional pediatric mortality surveillance information for current and past seasons:

[Surveillance Methods](#) | [FluView Interactive](#)

Additional national and international influenza surveillance information is available at:

<https://www.cdc.gov/flu/weekly/#AddInfo>

Report prepared: November 18, 2022

**WHO Collaborating Laboratory Reports
2022-2023 Influenza Season**

National

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	85	9083	19	39	238	0	3	5	0	250	75506	2085	2.76	1981	104
202241	85	8475	25	66	357	0	3	4	0	251	84991	3042	3.58	2956	86
202242	88	9329	48	104	431	1	3	6	0	252	89445	4893	5.47	4787	106
202243	87	9307	96	215	647	0	2	1	0	246	105719	8911	8.43	8800	111
202244	83	9890	310	262	690	0	4	2	0	241	115988	15487	13.35	15355	132
202245	82	7575	420	121	370	0	1	0	0	212	103830	15308	14.74	15185	123
Total	0	53659	918	807	2733	1	16	18	0	.	575479	49726	8.64	49064	662

Region 1 (CT, ME, MA, NH, RI, VT)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	8	1141	0	3	4	0	0	0	0	11	4684	30	0.64	30	0
202241	7	700	2	3	6	0	0	0	0	12	4707	37	0.79	35	2
202242	7	907	1	5	8	0	0	0	0	12	5231	63	1.20	61	2
202243	6	789	6	2	33	0	0	0	0	11	5885	128	2.18	124	4
202244	7	975	60	23	41	0	0	0	0	10	5793	293	5.06	291	2
202245	6	839	87	14	36	0	0	0	0	7	3227	230	7.13	229	1
Total	0	5351	156	50	128	0	0	0	0	.	29527	781	2.65	770	11

Region 2 (NJ, NY, PR)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	7	849	3	4	1	0	0	0	0	11	7652	32	0.42	31	1
202241	7	691	3	4	11	0	1	0	0	11	7827	59	0.75	58	1
202242	9	823	8	0	12	0	0	0	0	12	8523	116	1.36	116	0
202243	7	828	5	1	22	0	0	0	0	11	9955	336	3.38	335	1
202244	6	760	9	4	29	0	0	0	0	11	10535	716	6.80	712	4
202245	6	418	9	3	94	0	0	0	0	9	10436	1089	10.44	1086	3
Total	0	4369	37	16	169	0	1	0	0	.	54928	2348	4.27	2338	10

Region 3 (DE, DC, MD, PA, VA, WV)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVlc	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	8	1651	2	3	26	0	0	0	0	13	4342	68	1.57	67	1
202241	9	1674	2	11	30	0	0	0	0	13	4759	151	3.17	151	0
202242	8	1834	0	16	37	0	0	0	0	13	5307	288	5.43	288	0
202243	8	1876	1	42	53	0	0	0	0	13	6106	807	13.22	806	1
202244	9	1839	10	21	74	0	0	0	0	12	6641	1109	16.70	1108	1
202245	6	1475	7	9	38	0	0	0	0	10	5897	1086	18.42	1086	0
Total	0	10349	22	102	258	0	0	0	0	.	33052	3509	10.62	3506	3

Region 4 (AL, FL, GA, KY, MS, NC, SC, TN)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVlc	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	15	153	6	4	77	0	0	1	0	22	7553	657	8.70	619	38
202241	16	188	10	10	95	0	0	1	0	21	7598	738	9.71	708	30
202242	16	281	18	12	164	0	0	2	0	22	8317	1343	16.15	1322	21
202243	16	387	35	33	203	0	0	0	0	20	10639	1970	18.52	1933	37
202244	14	409	98	35	144	0	0	1	0	21	13352	2971	22.25	2929	42
202245	13	260	130	19	41	0	0	0	0	20	11715	2330	19.89	2267	63
Total	0	1678	297	113	724	0	0	5	0	.	59174	10009	16.91	9778	231

Region 5 (IL, IN, MI, MN, OH, WI)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVlc	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	14	2148	4	11	33	0	0	1	0	84	13976	149	1.07	127	22
202241	12	1968	1	21	77	0	0	1	0	85	16209	281	1.73	263	18
202242	10	2324	2	50	46	0	1	1	0	83	18630	584	3.13	566	18
202243	12	2246	6	94	71	0	1	0	0	80	21677	1304	6.02	1291	13
202244	10	2377	30	95	155	0	1	1	0	78	24481	2658	10.86	2631	27
202245	11	1841	72	51	47	0	1	0	0	72	16838	2410	14.31	2402	8
Total	0	12904	115	322	429	0	4	4	0	.	111811	7386	6.61	7280	106

Region 6 (AR, LA, NM, OK, TX)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVlc	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	10	833	1	7	12	0	1	0	0	28	12790	702	5.49	680	22
202241	16	750	3	11	15	0	1	0	0	28	17473	1159	6.63	1138	21
202242	13	644	9	9	40	1	0	0	0	27	13534	1500	11.08	1469	31
202243	13	612	23	21	42	0	0	0	0	27	17071	2673	15.66	2650	23
202244	11	412	14	35	17	0	0	0	0	26	14557	4044	27.78	4024	20
202245	10	312	11	3	2	0	0	0	0	23	14856	4149	27.93	4129	20
Total	0	3563	61	86	128	1	2	0	0	.	90281	14227	15.76	14090	137

Region 7 (IA, KS, MO, NE)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	8	186	1	0	1	0	0	0	0	42	6454	39	0.60	28	11
202241	9	173	1	2	5	0	0	0	0	41	6570	41	0.62	38	3
202242	9	229	4	1	14	0	2	0	0	41	7164	111	1.55	101	10
202243	9	226	12	1	25	0	0	0	0	41	7289	283	3.88	270	13
202244	10	240	8	9	20	0	0	0	0	42	9110	635	6.97	620	15
202245	8	190	21	3	9	0	0	0	0	37	8299	737	8.88	733	4
Total	0	1244	47	16	74	0	2	0	0	.	44886	1846	4.11	1790	56

Region 8 (CO, MT, ND, SD, UT, WY)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	7	200	0	1	5	0	0	0	0	11	2009	3	0.15	3	0
202241	7	145	1	1	8	0	0	2	0	11	1884	13	0.69	11	2
202242	7	158	1	2	20	0	0	3	0	11	1896	30	1.58	28	2
202243	7	191	2	11	32	0	0	0	0	11	2173	50	2.30	50	0
202244	6	199	2	21	55	0	0	0	0	10	2787	183	6.57	180	3
202245	8	159	10	15	22	0	0	0	0	10	3201	358	11.18	357	1
Total	0	1052	16	51	142	0	0	5	0	.	13950	637	4.57	629	8

Region 9 (AZ, CA, GU, HI, NV)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	34	1194	2	4	72	0	0	2	0	9	9841	361	3.67	355	6
202241	35	1246	2	1	106	0	1	0	0	10	11348	524	4.62	518	6
202242	32	1051	4	6	80	0	0	0	0	9	12811	758	5.92	743	15
202243	34	1045	6	4	150	0	1	1	0	10	16142	1114	6.90	1105	9
202244	33	1332	75	12	129	0	3	0	0	10	18045	2241	12.42	2231	10
202245	31	962	32	4	70	0	0	0	0	8	20583	2005	9.74	1994	11
Total	0	6830	121	31	607	0	5	3	0	.	88770	7003	7.89	6946	57

Region 10 (AK, ID, OR, WA)

CDC Week	Public Health Labs	Public Health Specimens Tested	AUNK	AH1N1 pdm09	AH3N2	AH3N2v	B	BVic	BYam	Clinical Labs	Clinical Specimens Tested	Clinical Flu Positive	% Positive	A	B
202240	6	728	0	2	7	0	2	1	0	22	6205	44	0.71	41	3
202241	6	940	0	2	4	0	0	0	0	23	6616	39	0.59	36	3
202242	6	1078	1	3	10	0	0	0	0	27	8032	100	1.25	93	7
202243	6	1107	0	6	16	0	0	0	0	26	8782	246	2.80	236	10
202244	6	1347	4	7	26	0	0	0	0	27	10687	637	5.96	629	8
202245	6	1119	41	0	11	0	0	0	0	21	8778	914	10.41	902	12
Total	0	6319	46	20	74	0	2	1	0	.	49100	1980	4.03	1937	43

**U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet)
2022-2023 Influenza Season
National (Baseline: 2.5%)
Data as of Friday, November 11, 2022**

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	3631	18433	19986	10685	4069	3837	57010	2198219	2.6	2.6
202241	3674	20624	22714	11507	4378	4047	63270	2214860	2.9	3.0
202242	3672	23696	28317	13700	5292	4492	75497	2269425	3.3	3.4
202243	3723	31919	44800	19534	6991	5825	109069	2447144	4.5	4.4
202244	3675	37317	60648	25361	8412	6778	138516	2483373	5.6	5.5
202245	3566	37752	54893	26289	9239	7371	135544	2373706	5.7	5.8

HHS Region 1 (CT, ME, MA, NH, RI, and VT) (Baseline: 2.0%)

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	258	755	805	490	234	285	2569	160547	1.6	1.4
202241	259	955	831	489	231	290	2796	163442	1.7	1.6
202242	263	1044	912	530	271	255	3012	166238	1.8	1.7
202243	262	1387	1172	680	277	332	3848	166387	2.3	2.1
202244	262	1646	1804	863	348	321	4982	172143	2.9	2.6
202245	253	1598	1729	922	416	354	5019	169274	3.0	2.7

HHS Region 2 (NJ, NY, PR, and USVI) (Baseline: 3.4%)

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	268	2093	2142	1622	532	375	6764	187310	3.6	3.2
202241	268	2244	1911	1162	399	320	6036	147834	4.1	4.3
202242	274	2858	2834	1872	605	462	8631	192022	4.5	4.4
202243	271	4048	4122	2249	709	526	11654	230988	5.0	4.7
202244	271	4925	6291	3046	910	610	15782	234710	6.7	6.5
202245	267	5365	6316	3334	1048	634	16697	229446	7.3	7.3

HHS Region 3 (DE, DC, MD, PA, VA, and WV) (Baseline: 2.1%)

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	388	2314	2151	940	376	410	6191	247231	2.5	2.2
202241	408	2531	2527	1034	455	363	6910	246047	2.8	2.6
202242	403	3097	3797	1371	565	501	9331	265766	3.5	3.1
202243	403	4220	6362	2059	801	624	14066	275058	5.1	4.4
202244	394	4857	9153	3185	969	748	18912	283763	6.7	5.6
202245	391	4968	8314	3330	1055	818	18485	281652	6.6	5.6

HHS Region 4 (AL, FL, GA, KY, MS, NC, SC, and TN) (Baseline: 3.1%)

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	946	6187	7273	2923	1070	978	18431	570766	3.2	3.3
202241	953	6616	8652	3617	1182	1152	21219	581102	3.7	3.8
202242	899	7326	10502	4318	1502	1311	24959	584695	4.3	4.4
202243	957	10324	19366	7279	2286	1889	41144	630448	6.5	6.8
202244	953	12090	25090	9610	2822	2255	51867	652311	8.0	8.4
202245	944	11232	19446	9198	2976	2414	45266	614227	7.4	7.7

HHS Region 5 (IL, IN, MI, MN, OH, and WI) (Baseline: 2.5%)

CDC Week	# Sites Reporting	ILI 0-4 years	ILI 5-24 years	ILI 25-49 years	ILI 50-64 years	ILI 65 years and older	Total ILI	Total Patient Visits	% Unweighted ILI	% Weighted ILI
202240	617	2440	2015	790	354	333	5932	297459	2.0	2.1
202241	621	3015	2301	970	381	419	7086	325812	2.2	2.3
202242	627	3219	2422	939	407	349	7336	287992	2.5	2.6
202243	623	4011	3201	1198	489	516	9415	338485	2.8	2.9
202244	619	4487	4713	1364	487	479	11530	336651	3.4	3.7
202245	577	4430	4627	1402	491	469	11419	315622	3.6	4.0

HHS Region 6 (AR, LA, NM, OK, and TX) (Baseline: 3.9%)

<i>CDC Week</i>	<i># Sites Reporting</i>	<i>ILI 0-4 years</i>	<i>ILI 5-24 years</i>	<i>ILI 25-49 years</i>	<i>ILI 50-64 years</i>	<i>ILI 65 years and older</i>	<i>Total ILI</i>	<i>Total Patient Visits</i>	<i>% Unweighted ILI</i>	<i>% Weighted ILI</i>
202240	261	1702	2179	669	242	188	4980	153585	3.2	3.9
202241	268	1997	2692	881	367	239	6176	162269	3.8	4.5
202242	263	2058	3164	1061	418	247	6948	162270	4.3	5.0
202243	263	2715	4730	1524	514	338	9821	170883	5.7	6.6
202244	261	3088	5779	1824	644	409	11744	174657	6.7	7.5
202245	258	2898	4300	1606	511	430	9745	154024	6.3	7.3

HHS Region 7 (IA, KS, MO, and NE) (Baseline: 1.8%)

<i>CDC Week</i>	<i># Sites Reporting</i>	<i>ILI 0-4 years</i>	<i>ILI 5-24 years</i>	<i>ILI 25-49 years</i>	<i>ILI 50-64 years</i>	<i>ILI 65 years and older</i>	<i>Total ILI</i>	<i>Total Patient Visits</i>	<i>% Unweighted ILI</i>	<i>% Weighted ILI</i>
202240	159	458	411	182	77	58	1186	58760	2.0	1.8
202241	157	466	417	196	91	106	1276	59509	2.1	1.9
202242	170	602	537	209	64	91	1503	69029	2.2	2.0
202243	171	707	613	294	131	99	1844	72717	2.5	2.3
202244	170	823	900	367	139	125	2354	71546	3.3	3.0
202245	168	831	1043	406	152	115	2547	71093	3.6	3.3

HHS Region 8 (CO, MT, ND, SD, UT, and WY) (Baseline: 2.8%)

<i>CDC Week</i>	<i># Sites Reporting</i>	<i>ILI 0-4 years</i>	<i>ILI 5-24 years</i>	<i>ILI 25-49 years</i>	<i>ILI 50-64 years</i>	<i>ILI 65 years and older</i>	<i>Total ILI</i>	<i>Total Patient Visits</i>	<i>% Unweighted ILI</i>	<i>% Weighted ILI</i>
202240	190	391	464	228	65	63	1211	72575	1.7	1.8
202241	193	404	479	237	65	61	1246	69616	1.8	1.9
202242	229	761	711	351	157	141	2121	92267	2.3	2.2
202243	230	992	905	432	168	170	2667	93899	2.8	2.7
202244	227	1230	1333	551	208	234	3556	95235	3.7	3.5
202245	225	1625	1828	717	291	237	4698	95059	4.9	4.7

HHS Region 9 (AZ, CA, HI, and NV) (Baseline: 2.4%)

<i>CDC Week</i>	<i># Sites Reporting</i>	<i>ILI 0-4 years</i>	<i>ILI 5-24 years</i>	<i>ILI 25-49 years</i>	<i>ILI 50-64 years</i>	<i>ILI 65 years and older</i>	<i>Total ILI</i>	<i>Total Patient Visits</i>	<i>% Unweighted ILI</i>	<i>% Weighted ILI</i>
202240	341	1856	2217	2659	1045	1058	8835	361925	2.4	2.2
202241	344	2076	2559	2709	1124	1012	9480	365577	2.6	2.4
202242	340	2418	3097	2858	1219	1047	10639	370402	2.9	2.7
202243	339	3040	3801	3538	1517	1230	13126	371556	3.5	3.3
202244	314	3391	4673	4136	1754	1477	15431	361031	4.3	4.1
202245	281	3681	5771	4748	2072	1689	17961	339012	5.3	5.2

HHS Region 10 (AK, ID, OR, and WA) (Baseline: 1.8%)

<i>CDC Week</i>	<i># Sites Reporting</i>	<i>ILI 0-4 years</i>	<i>ILI 5-24 years</i>	<i>ILI 25-49 years</i>	<i>ILI 50-64 years</i>	<i>ILI 65 years and older</i>	<i>Total ILI</i>	<i>Total Patient Visits</i>	<i>% Unweighted ILI</i>	<i>% Weighted ILI</i>
202240	203	237	329	182	74	89	911	88061	1.0	1.0
202241	203	320	345	212	83	85	1045	93652	1.1	1.2
202242	204	313	341	191	84	88	1017	78744	1.3	1.4
202243	204	475	528	281	99	101	1484	96723	1.5	1.6
202244	204	780	912	415	131	120	2358	101326	2.3	2.4
202245	202	1124	1519	626	227	211	3707	104297	3.6	3.7

**U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), by Age Group
2021-2022 and 2022-2023 Influenza Seasons**

MMWR Week	0-4 years		5-24 years		25-49 years		50-64 years		65 years and older	
	Patient Visits	ILI %	Patient Visits	ILI %	Patient Visits	ILI %	Patient Visits	ILI %	Patient Visits	ILI %
202221	116070	9.6	306532	5.2	469452	1.7	260097	1.2	318373	0.9
202222	115984	10.2	284732	4.8	453673	1.8	254079	1.2	314988	0.9
202223	110766	9.3	275501	3.8	461255	1.6	259493	1.2	317412	0.9
202224	105170	8.8	263301	3.1	457746	1.4	257226	1.0	316787	0.8
202225	104182	7.9	260549	2.7	462099	1.4	259800	1.0	319782	0.8
202226	102271	7.5	256559	2.3	456615	1.3	257180	1.0	321279	0.8
202227	99760	7.2	259628	2.3	468028	1.3	262876	1.0	324936	0.8
202228	99151	6.5	261988	2.1	472847	1.2	265238	1.0	327177	0.8
202229	98301	6.4	263095	2.1	473996	1.2	264935	0.9	326595	0.8
202230	97204	6.4	263113	2.1	468394	1.2	261153	0.9	319997	0.8
202231	95624	6.1	264998	1.9	464093	1.1	258510	0.8	319652	0.7
202232	93290	5.9	261877	2.0	450442	1.1	252389	0.8	311661	0.7
202233	98008	6.3	276589	2.4	453879	1.0	255897	0.8	317254	0.6
202234	104407	7.0	292640	2.9	454606	1.1	254993	0.7	314078	0.6
202235	109104	7.2	304260	3.1	461455	1.1	256386	0.7	320385	0.6
202236	113016	7.8	300124	3.1	458587	1.1	256218	0.8	319221	0.6
202237	115584	8.1	312914	3.2	457279	1.1	257947	0.7	320552	0.5
202238	122272	9.0	319814	3.5	458707	1.1	257544	0.7	321491	0.6
202239	124265	9.5	305141	3.6	441370	1.1	250379	0.8	324149	0.6
202240	124648	9.8	307040	3.9	475806	1.4	282662	0.9	366072	0.7
202241	131288	10.5	316949	4.4	486304	1.6	286501	1.0	365055	0.8
202242	137975	11.5	326816	5.4	480497	1.9	284247	1.3	363520	0.9
202243	159363	13.7	371541	7.7	517435	2.6	302634	1.6	384106	1.1
202244	168134	15.3	401167	9.9	527245	3.4	302326	1.9	381497	1.3
202245	167061	15.9	371874	9.9	517726	3.6	298686	2.2	373119	1.5

**Number of Long-term Care Facilities (LTCF) Reporting at least One Confirmed Influenza Positive Test Among Residents
Reported to CDC National Healthcare Safety Network (NHSN),
May 23, 2022- November 13, 2022
Data as of November 16, 2022**

National			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	15,644	71	0.45
202222	15,643	87	0.56
202223	15,642	60	0.38
202224	15,639	46	0.29
202225	15,643	39	0.25
202226	15,660	37	0.24
202227	15,655	24	0.15
202228	15,640	33	0.21
202229	15,646	41	0.26
202230	15,581	40	0.26
202231	15,646	42	0.27
202232	15,637	41	0.26
202233	15,629	33	0.21
202234	15,574	31	0.20
202235	15,599	33	0.21
202236	15,600	27	0.17
202237	15,578	35	0.22
202238	15,568	35	0.22
202239	15,547	39	0.25
202240	15,525	51	0.33
202241	15,425	72	0.47
202242	15,408	79	0.51
202243	15,312	130	0.85
202244	15,259	155	1.02
202245	14,161	174	1.23

Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	863	10	1.16
202222	859	6	0.70
202223	857	4	0.47
202224	856	2	0.23
202225	856	2	0.23
202226	855	1	0.12
202227	855	1	0.12
202228	859	0	0.00
202229	857	1	0.12
202230	852	0	0.00
202231	858	4	0.47
202232	856	1	0.12
202233	856	0	0.00
202234	858	3	0.35
202235	858	2	0.23
202236	860	0	0.00
202237	859	2	0.23
202238	857	2	0.23
202239	857	3	0.35
202240	857	2	0.23
202241	859	6	0.70
202242	855	2	0.23
202243	858	4	0.47
202244	850	4	0.47
202245	742	5	0.67

Region 2 (New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	1,086	6	0.55
202222	1,085	8	0.74
202223	1,090	3	0.28
202224	1,090	5	0.46
202225	1,092	3	0.27
202226	1,084	1	0.09
202227	1,090	3	0.28
202228	1,084	4	0.37
202229	1,085	5	0.46
202230	1,073	8	0.75
202231	1,084	1	0.09
202232	1,085	3	0.28
202233	1,083	1	0.09
202234	1,076	4	0.37
202235	1,078	2	0.19
202236	1,075	4	0.37
202237	1,078	1	0.09
202238	1,081	3	0.28
202239	1,077	2	0.19
202240	1,076	4	0.37
202241	1,074	6	0.56
202242	1,073	9	0.84
202243	1,064	7	0.66
202244	1,057	5	0.47
202245	977	10	1.02

Region 3 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)

Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	1,398	7	0.50
202222	1,382	2	0.14
202223	1,394	3	0.22
202224	1,394	2	0.14
202225	1,387	2	0.14
202226	1,393	5	0.36
202227	1,391	2	0.14
202228	1,392	4	0.29
202229	1,393	5	0.36
202230	1,387	3	0.22
202231	1,389	1	0.07
202232	1,393	2	0.14
202233	1,394	10	0.72
202234	1,390	6	0.43
202235	1,392	2	0.14
202236	1,386	2	0.14
202237	1,385	5	0.36
202238	1,382	4	0.29
202239	1,383	4	0.29
202240	1,378	4	0.29
202241	1,383	6	0.43
202242	1,379	9	0.65
202243	1,370	14	1.02
202244	1,364	19	1.39
202245	1,197	16	1.34

Region 4 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	2,747	12	0.44
202222	2,749	29	1.05
202223	2,753	16	0.58
202224	2,759	13	0.47
202225	2,756	14	0.51
202226	2,759	13	0.47
202227	2,761	6	0.22
202228	2,755	6	0.22
202229	2,755	12	0.44
202230	2,746	6	0.22
202231	2,755	11	0.40
202232	2,752	6	0.22
202233	2,752	4	0.15
202234	2,740	8	0.29
202235	2,742	11	0.40
202236	2,745	9	0.33
202237	2,740	8	0.29
202238	2,738	10	0.37
202239	2,736	13	0.48
202240	2,731	18	0.66
202241	2,715	16	0.59
202242	2,713	26	0.96
202243	2,699	49	1.82
202244	2,703	71	2.63
202245	2,523	68	2.70

Region 5 (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	3,456	14	0.41
202222	3,456	11	0.32
202223	3,438	13	0.38
202224	3,431	11	0.32
202225	3,460	8	0.23
202226	3,461	6	0.17
202227	3,464	3	0.09
202228	3,458	5	0.14
202229	3,463	6	0.17
202230	3,448	7	0.20
202231	3,461	6	0.17
202232	3,456	10	0.29
202233	3,455	6	0.17
202234	3,450	5	0.14
202235	3,455	6	0.17
202236	3,456	8	0.23
202237	3,446	6	0.17
202238	3,449	5	0.14
202239	3,443	6	0.17
202240	3,440	6	0.17
202241	3,351	9	0.27
202242	3,340	6	0.18
202243	3,318	17	0.51
202244	3,309	16	0.48
202245	3,147	26	0.83

Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	2,093	5	0.24
202222	2,097	10	0.48
202223	2,099	6	0.29
202224	2,098	5	0.24
202225	2,088	4	0.19
202226	2,098	3	0.14
202227	2,097	4	0.19
202228	2,096	7	0.33
202229	2,095	3	0.14
202230	2,092	4	0.19
202231	2,096	9	0.43
202232	2,099	12	0.57
202233	2,097	3	0.14
202234	2,078	3	0.14
202235	2,082	5	0.24
202236	2,083	1	0.05
202237	2,084	6	0.29
202238	2,082	5	0.24
202239	2,078	5	0.24
202240	2,080	11	0.53
202241	2,081	20	0.96
202242	2,081	15	0.72
202243	2,064	21	1.02
202244	2,049	21	1.02
202245	1,874	27	1.44

Region 7 (Iowa, Kansas, Missouri, and Nebraska)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	1,497	2	0.13
202222	1,507	1	0.07
202223	1,503	4	0.27
202224	1,503	2	0.13
202225	1,498	3	0.20
202226	1,504	1	0.07
202227	1,494	2	0.13
202228	1,499	5	0.33
202229	1,497	3	0.20
202230	1,484	7	0.47
202231	1,498	6	0.40
202232	1,493	5	0.33
202233	1,493	3	0.20
202234	1,490	1	0.07
202235	1,493	2	0.13
202236	1,494	2	0.13
202237	1,491	5	0.34
202238	1,489	4	0.27
202239	1,486	0	0.00
202240	1,478	1	0.07
202241	1,474	3	0.20
202242	1,478	4	0.27
202243	1,462	8	0.55
202244	1,460	8	0.55
202245	1,370	11	0.80

Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	606	5	0.83
202222	606	11	1.82
202223	609	3	0.49
202224	608	2	0.33
202225	606	0	0.00
202226	607	0	0.00
202227	603	1	0.17
202228	602	0	0.00
202229	601	2	0.33
202230	600	3	0.50
202231	603	1	0.17
202232	600	0	0.00
202233	602	1	0.17
202234	599	0	0.00
202235	601	0	0.00
202236	600	0	0.00
202237	597	1	0.17
202238	596	1	0.17
202239	592	2	0.34
202240	590	0	0.00
202241	593	0	0.00
202242	596	3	0.50
202243	586	5	0.85
202244	584	2	0.34
202245	537	3	0.56

Region 9 (Arizona, California, Hawaii, and Nevada)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	1,462	4	0.27
202222	1,465	8	0.55
202223	1,462	6	0.41
202224	1,462	2	0.14
202225	1,463	2	0.14
202226	1,462	6	0.41
202227	1,461	2	0.14
202228	1,461	1	0.07
202229	1,461	2	0.14
202230	1,459	1	0.07
202231	1,460	2	0.14
202232	1,461	2	0.14
202233	1,459	3	0.21
202234	1,456	1	0.07
202235	1,457	2	0.14
202236	1,459	0	0.00
202237	1,456	1	0.07
202238	1,454	1	0.07
202239	1,455	3	0.21
202240	1,456	5	0.34
202241	1,456	6	0.41
202242	1,456	5	0.34
202243	1,452	4	0.28
202244	1,451	6	0.41
202245	1,417	4	0.28

Region 10 (Alaska, Idaho, Oregon, and Washington)			
Week	Number of LTCFs Reporting	Number of LTCFs with ≥ 1 influenza positive test among residents	% of LTCFs with ≥ 1 influenza positive test among residents
202221	436	6	1.38
202222	437	1	0.23
202223	437	2	0.46
202224	438	2	0.46
202225	437	1	0.23
202226	437	1	0.23
202227	439	0	0.00
202228	434	1	0.23
202229	439	2	0.46
202230	440	1	0.23
202231	442	1	0.23
202232	442	0	0.00
202233	438	2	0.46
202234	437	0	0.00
202235	441	1	0.23
202236	442	1	0.23
202237	442	0	0.00
202238	440	0	0.00
202239	440	1	0.23
202240	439	0	0.00
202241	439	0	0.00
202242	437	0	0.00
202243	439	1	0.23
202244	432	3	0.69
202245	377	4	1.06

**New Influenza Hospital Admissions Reported to HHS Protect
May 22, 2022- November 12, 2022
Data as of November 16, 2022**

National		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	5,072	2,675
202222	5,073	2,614
202223	5,079	2,094
202224	5,081	1,729
202225	5,083	1,308
202226	5,084	1,009
202227	5,080	759
202228	5,082	727
202229	5,087	587
202230	5,085	493
202231	5,082	516
202232	5,085	464
202233	5,077	485
202234	5,067	490
202235	5,062	522
202236	5,057	582
202237	5,066	644
202238	5,069	742
202239	5,068	897
202240	5,073	1,332
202241	5,075	1,692
202242	5,072	2,362
202243	5,067	4,354
202244	5,060	6,529
202245	4,987	8,707

Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	192	136
202222	192	84
202223	193	100
202224	193	33
202225	193	19
202226	193	20
202227	193	13
202228	193	10
202229	193	12
202230	193	7
202231	193	9
202232	194	4
202233	193	4
202234	193	13
202235	193	8
202236	192	5
202237	193	9
202238	193	9
202239	193	8
202240	193	13
202241	194	16
202242	194	20
202243	193	55
202244	193	82
202245	193	123

Region 2 (New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	296	271
202222	296	189
202223	296	163
202224	293	170
202225	295	92
202226	296	83
202227	294	66
202228	293	65
202229	295	36
202230	290	40
202231	294	44
202232	294	38
202233	292	44
202234	295	58
202235	295	58
202236	293	59
202237	292	78
202238	292	81
202239	291	87
202240	291	107
202241	294	136
202242	296	135
202243	296	259
202244	293	490
202245	283	697

Region 3 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	378	159
202222	378	139
202223	378	122
202224	379	102
202225	378	92
202226	379	87
202227	378	71
202228	379	53
202229	380	68
202230	380	51
202231	380	47
202232	380	55
202233	379	61
202234	379	41
202235	379	62
202236	379	58
202237	380	67
202238	379	58
202239	379	93
202240	380	136
202241	379	167
202242	379	264
202243	379	555
202244	378	842
202245	374	1,090

Region 4 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	936	719
202222	934	844
202223	934	698
202224	936	623
202225	937	448
202226	936	315
202227	935	260
202228	937	232
202229	937	191
202230	937	160
202231	937	178
202232	938	139
202233	937	117
202234	936	142
202235	933	136
202236	928	172
202237	932	210
202238	936	237
202239	932	273
202240	935	407
202241	936	531
202242	932	737
202243	926	1,433
202244	923	2,062
202245	910	2,443

Region 5 (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	889	247
202222	889	174
202223	889	108
202224	888	97
202225	889	71
202226	889	51
202227	889	36
202228	889	36
202229	889	31
202230	889	37
202231	888	31
202232	888	29
202233	888	36
202234	888	47
202235	889	47
202236	889	57
202237	889	39
202238	888	74
202239	889	68
202240	889	104
202241	888	146
202242	887	191
202243	888	427
202244	887	705
202245	873	937

Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	864	220
202222	869	218
202223	874	160
202224	874	182
202225	875	152
202226	875	123
202227	877	90
202228	874	140
202229	876	111
202230	877	71
202231	875	96
202232	873	98
202233	871	111
202234	871	108
202235	870	114
202236	870	159
202237	872	157
202238	872	176
202239	873	203
202240	871	336
202241	871	490
202242	870	721
202243	873	1,131
202244	874	1,438
202245	866	1,737

Region 7 (Iowa, Kansas, Missouri, and Nebraska)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	462	30
202222	462	46
202223	463	37
202224	463	31
202225	463	32
202226	463	27
202227	462	26
202228	462	18
202229	463	18
202230	463	21
202231	463	26
202232	462	19
202233	462	23
202234	461	14
202235	462	20
202236	461	8
202237	459	14
202238	459	24
202239	459	35
202240	459	38
202241	458	35
202242	459	62
202243	459	110
202244	457	148
202245	448	195

Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	334	111
202222	334	110
202223	333	55
202224	333	31
202225	333	16
202226	333	23
202227	332	16
202228	332	14
202229	333	17
202230	333	19
202231	333	21
202232	334	17
202233	334	20
202234	334	6
202235	333	12
202236	333	11
202237	332	11
202238	332	13
202239	332	15
202240	331	14
202241	331	24
202242	333	37
202243	331	64
202244	330	63
202245	325	121

Region 9 (Arizona, California, Hawaii, and Nevada)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	503	687
202222	503	706
202223	503	564
202224	504	397
202225	503	306
202226	502	223
202227	502	148
202228	505	119
202229	504	79
202230	505	69
202231	501	45
202232	504	49
202233	503	55
202234	492	53
202235	491	54
202236	496	37
202237	499	42
202238	501	56
202239	503	102
202240	505	155
202241	506	125
202242	505	165
202243	506	265
202244	507	581
202245	502	1,193

Region 10 (Alaska, Idaho, Oregon, and Washington)		
Week	Number of Hospitals Reporting (7 Day Average)	Number of New Influenza Admissions
202221	217	95
202222	217	104
202223	218	87
202224	218	63
202225	218	80
202226	218	57
202227	218	33
202228	218	40
202229	218	24
202230	218	18
202231	218	19
202232	218	16
202233	218	14
202234	217	8
202235	217	11
202236	217	16
202237	218	17
202238	218	14
202239	218	13
202240	218	22
202241	218	22
202242	218	30
202243	217	55
202244	217	118
202245	214	171

NCHS Mortality Surveillance Data
Data as of November 17, 2022
For the Week Ending November 12 2022 (Week 45)

Year	Week	Percent of Deaths Due to Pneumonia and Influenza (P&I)	Percent of Deaths Due to Pneumonia, Influenza or COVID-19 (PIC)	Expected	Threshold	All Deaths	Pneumonia Deaths	Influenza Deaths	COVID-19 Deaths	Pneumonia, Influenza or COVID-19 Deaths (PIC)
2022	40	5.95	8.37	5.45	5.75	57152	3375	24	2083	4785
2022	41	5.99	8.37	5.53	5.83	56310	3323	51	1986	4715
2022	42	6.44	8.87	5.62	5.92	53826	3423	45	1978	4776
2022	43	6.19	8.67	5.72	6.02	47797	2891	69	1821	4145
2022	44	6.35	8.81	5.82	6.12	40787	2498	91	1542	3593
2022	45	6.77	9.44	5.92	6.22	23043	1491	70	926	2175

7. Supplemental Materials:

- **Council Constitution and Bylaws**
- **Council Participation Agreement**
- **Council Strategic Directions, 2016-2020**



**Council on Linkages Between Academia and
Public Health Practice**

Constitution and Bylaws

ARTICLE I. – MISSION:

The mission of the Council on Linkages Between Academia and Public Health Practice (Council) is to improve the performance of individuals and organizations within public health by fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities; promoting public health education and training for health professionals throughout their careers; and developing and advancing innovative strategies to build and strengthen public health infrastructure.

ARTICLE II. – BACKGROUND AND PURPOSE:

In order to bridge the perceived gap between the academic and practice communities that was documented in the 1988 Institute of Medicine report, *The Future of Public Health*, the Public Health Faculty/Agency Forum was established in 1990.

After nearly two years of deliberations and a public comment period, the Forum released its final report entitled, *The Public Health Faculty/Agency Forum: Linking Graduate Education and Practice*. The report offers recommendations for: 1) strengthening relationships between public health academicians and public health practitioners in public agencies; 2) improving the teaching, training, and practice of public health; 3) establishing firm practice links between schools of public health and public agencies; and 4) collaborating with others in achieving the nation's Year 2000 health objectives. In addition, the Public Health Faculty/Agency Forum issued a list of "Universal Competencies" to help guide the education and training of public health professionals.

The Council was formed initially to help implement these recommendations and competencies. Over time, the Council's mission and corollary objectives may be amended to best serve the needs of public health's academic and practice communities.

ARTICLE III. – MEMBERSHIP:

A. Member Composition:

The Council is comprised of national public health academic and practice agencies, organizations, and associations that desire to work together to help build academic/practice linkages in public health. Membership on the Council is limited to any agency, organization, or association that:

1. Can demonstrate that agency, organization, or association is national in scope.
2. Is unique and not currently represented by existing Council Member Organizations.
3. Has a mission consistent with the Council's mission and objectives.
4. Is willing to participate as a Preliminary Member Organization on the Council for one year prior to formal membership, at the participating organization's expense.
5. Upon being granted formal membership status, signs the Council's Participation Agreement.

Individuals may not join the Council.

B. Member Organizations:

Council Member Organizations include:

- American Association of Colleges of Nursing (AACN)
- American College of Preventive Medicine (ACPM)
- American Public Health Association (APHA)
- Association for Prevention Teaching and Research (APTR)
- Association of Accredited Public Health Programs (AAPHP)
- Association of Public Health Laboratories (APHL)
- Association of Schools and Programs of Public Health (ASPPH)
- Association of State and Territorial Health Officials (ASTHO)
- Association of University Programs in Health Administration (AUPHA)
- Centers for Disease Control and Prevention (CDC)
- Community-Campus Partnerships for Health (CCPH)
- Council of Public Health Nursing Organizations (CPHNO)
- Council of State and Territorial Epidemiologists (CSTE) – Preliminary Member Organization
- Council on Education for Public Health (CEPH)
- Health Resources and Services Administration (HRSA)
- National Association of County and City Health Officials (NACCHO)
- National Association of Local Boards of Health (NALBOH)
- National Board of Public Health Examiners (NBPHE)
- National Environmental Health Association (NEHA)
- National Library of Medicine (NLM)
- National Network of Public Health Institutes (NNPHI)
- Public Health Accreditation Board (PHAB) – Preliminary Member Organization
- Society for Public Health Education (SOPHE)
- Veterans Health Administration (VHA)

Membership Categories:

An organization must petition the Council to become a member in accordance with the Council's membership policy. If membership is granted, the agency, organization, or association will become a Preliminary Member Organization for the period of one year. At the conclusion of one year as a Preliminary Member Organization, the Council will vote to approve or decline the agency, organization, or association as a Formal Member Organization. If granted formal membership status, the agency, organization, or association will be reimbursed for travel related expenses for future meetings, if funds permit.

I. Preliminary Member Organization Privileges

1. Preliminary Member Organizations may fully participate in all discussions and activities associated with Council meetings at which they are required to attend.
2. Preliminary Member Organizations retain the right to vote at Council meetings during their preliminary term.
3. Preliminary Member Organizations can participate in any and all Council subcommittee/taskforce discussions that they desire to join.
4. Preliminary Member Organizations' names and/or logos will be included in Council resources that depict Member Organizations during the preliminary term.

5. Preliminary Member Organizations will be responsible for all travel related expenses for attending meetings.

II. Formal Member Organization Privileges

1. In accordance with the Council's travel policy and as funding permits, Organizational Representatives (Representatives) from Formal Member Organizations are entitled to reimbursement up to a predetermined amount for airfare, transportation to and from meeting site, and hotel accommodations for Council meeting travel.
2. As funding permits, Representatives from Formal Member Organizations will be reimbursed at the federally-approved per diem rate for meals consumed during travel to and from Council meetings.
3. Substitutes for officially designated Representatives are not eligible for travel reimbursement.
4. Formal Member Organizations retain full participation privileges in all Council discussions, activities, votes, and subcommittee/taskforces.
5. Formal Member Organizations will be represented either via logo or text in all Council resources that depict membership.
6. Formal Member Organizations must comply with the signed Participation Agreement.
7. Representatives from federal government agencies will not receive funding from the Council for travel or related expenses.

ARTICLE IV. – MEMBER ORGANIZATION RESPONSIBILITIES:

In order for the Council to meet its goals and corollary objectives, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council membership requires that:

- Each Member Organization (Organization) select an appropriate Representative to serve on the Council for, at a minimum, one year. Organizations are strongly encouraged to select Representatives who can serve for terms of two or more years.
- The Representative have access to and communicate regularly with the Organization's leadership about Council activities.
- The Representative be able to present the perspectives of the Organization during Council meetings.
- The Representative attend and actively participate in scheduled meetings and shall not miss two consecutive meetings during a given year unless the absence is communicated to Council staff and approved by the Chair before the scheduled meeting.
- Each Organization identify a key staff contact who will keep abreast of Council activities via interaction with Council staff, attendance at locally-held meetings, and/or regular contact with the Representative.
- During at least one meeting each year, Representatives present the progress their respective Organizations and members have made toward implementing and sustaining productive academic/practice linkages.

- Each Representative (or staff contact) respond to requests for assistance with writing and compiling Council documents and resources.
- Representatives and Organizations disseminate information on linkage activities using media generally available to the Council's constituency and specifically to the respective memberships of the Organizations.
- Upon request of the Council Chair, Representatives officially represent the Council at meetings or presentations widely attended by members of the practice and academic public health communities.
- Upon request of the Council Chair, Representatives assist Council staff with identifying and securing funding for projects, advocating Organizational support for specific initiatives, and serving on Council subcommittees.

If a Representative or Organization does not fulfill the above responsibilities, Council staff will first contact the Representative and Organization in writing. If a Representative fails to address the concerns—for example, in the case of chronic absenteeism at Council meetings—the Council chair may request that a new Representative be selected. Then, if a Member Organization consistently fails to perform its responsibilities after a written warning, Council staff will inform that Organization in writing that the full Council will vote on revoking that Organization's membership. If a majority of all Representatives vote to revoke an Organization's membership, that Organization will no longer be considered a part of the Council.

ARTICLE V. – Discussions, Decisions, and Voting:

A. The following overlying principle shall govern decisions within the Council:

Each Member Organization shall have one vote. Only Representatives or officially designated substitutes can vote. To designate a substitute, Member Organizations must provide the name and contact information for that individual to Council staff in advance of the meeting.

B. Discussions & Decisions:

Council meetings will use a modified form of parliamentary procedure where discussions among the Representatives will be informal to assure that adequate consideration is given to a particular issue being discussed by the Council. However, decisions will be formal, using Robert's Rules of Order (recording the precise matters to be considered, the decisions made, and the responsibilities accepted or assigned).

C. Voting:

1. Each Representative shall have one vote. If a Representative is unable to attend a meeting, the Organization may designate a substitute (or Designee) for the meeting. That Designee will have voting privileges for the meeting.
2. **Quorum** is required for a vote to be taken and shall consist of a majority of the Representatives or Designees of all participating groups composing the Council.
3. **Simple Majority** Vote will be required for internal Council administrative, operational, and membership matters (i.e.: Minutes approvals).
4. The Council will seek **Consensus** (Quaker style – No-one blocking consensus) when developing major new directions for the Council (i.e.: moving forward with studying leadership tier of credentialing). No more than one-quarter of

Representatives or their Designees can abstain, or the motion will not pass. Representatives will be expected to confer with the leadership of their organizations prior to the meeting to ensure that their votes reflect the Organization's views on the topic.

5. A two-thirds **Super Majority** of all Representatives will be required to vote on accepting or amending this Constitution and Bylaws.

ARTICLE VI. – COUNCIL LEADERSHIP:

One Representative will serve as the Council Chair. The Chair is charged with opening and closing meetings, calling all votes, and working with Council staff to set meeting agendas.

The term of the Chair is two years. There is no limit to the number of terms a Representative can serve as Chair. At the end of each two-year term, another Council Representative and/or the current Chair may nominate him/herself or be nominated for the position of Chair. To be elected Chair requires a majority affirmative vote of Council membership. In the event that there are several nominees and no nominee receives a clear majority of the vote, a runoff will be held among the individuals who received the highest number of votes.

To be eligible to serve as Chair, an individual must:

- have served as a Council Representative for at least two years; and
- have some experience working in public health practice.

ARTICLE VII. – MEETINGS:

The Council shall convene at least one in-person meeting a year. Funds permitting, the Council will convene additional meetings either in-person or via conference call. All meetings are open to the public.

ARTICLE VIII. – COUNCIL STAFF ROLES AND RESPONSIBILITIES:

The Council is staffed by the Public Health Foundation. Council staff provide administrative support to the Council and its Organizations and Representatives. This includes, but is not limited to:

1. Planning and convening Council meetings;
2. General Council administration such as drafting meeting minutes, yearly deliverables, progress reports, action plans, etc.;
3. Working with Representatives and their Organizations to secure core and special project funding for Council activities and initiatives; and
4. Officially representing the Council at meetings related to education and practice.

ARTICLE IX. – FUNDING:

Council staff, with approval from the Council Chair, may seek core and special project funding on behalf of the Council in accordance with Council-approved objectives, strategies, and deliverables.

Adopted: January 24, 2006

Amended: January 27, 2012

Article I. Mission Updated:

Article III.B. Member Organizations Updated:

October 7, 2016

September 6, 2013; March 31, 2014; August 19, 2015; January 20, 2016; August 18, 2016; May 1, 2017; October 18, 2017; December 20, 2017; May 11, 2021; May 19, 2021; September 23, 2021; December 15, 2021; August 8, 2022

The Council on Linkages Between Academia and Public Health Practice (Council) exists to improve the performance of individuals and organizations within public health by fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities; promoting public health education and training for health professionals throughout their careers; and developing and advancing innovative strategies to build and strengthen public health infrastructure. In order to fulfill this mission, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council involvement requires that:

- The Member Organization (Organization) selects an appropriate Representative (Representative) to serve on the Council for, at a minimum, one year. Organizations are strongly encouraged to select Representatives who can serve for terms of two or more years.
- The Representative has access to and communicates regularly with the Organization's leadership about Council activities.
- The Representative is able to present the perspectives of the Organization during Council meetings.
- The Representative attends and actively participates in scheduled meetings and does not miss two consecutive meetings during a given year unless the absence is communicated to Council staff and approved by the Chair before the scheduled meeting.
- The Organization identifies a key staff contact who will keep abreast of Council activities via interaction with Council staff, attendance at locally-held meetings, and/or regular contact with the Representative.
- During at least one meeting each year, the Representative presents the progress his/her respective Organization and members have made toward implementing and sustaining productive academic/practice linkages.
- The Representative and Organization contribute to the Council's understanding of how Council initiatives and products are being used by the members/constituents of the Council Organization.
- The Representative (or staff contact) responds to requests for assistance with writing and compiling Council documents and resources.
- The Representative and Organization disseminate information on linkage activities using media generally available to the Council's constituency and specifically to the respective membership of the Council Organization.
- Upon request of the Council Chair, the Representative officially represents the Council at meetings or presentations widely attended by members of the practice and academic public health communities.

- Upon request of the Council Chair, the Representative assists Council staff with identifying and securing funding for projects, advocating Organizational support for specific initiatives, and serving on Council subcommittees.

We have read and understand the Participation Agreement described above and agree to the obligations and conditions for membership on the Council on Linkages Between Academia and Public Health Practice. We understand that membership and representation is voluntary, and we may withdraw Representative and/or Organizational participation at any time if we are unable to meet the above outlined responsibilities.

Council Representative Designated by Organization

Date

Organizational Executive Director

Date

Member Organization



Council on Linkages Between Academia and Public Health Practice: Strategic Directions, 2016-2020

Mission

To improve the performance of individuals and organizations within public health by:

- Fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities;
- Promoting public health education and training for health professionals throughout their careers; and
- Developing and advancing innovative strategies to build and strengthen public health infrastructure.

Values

- Teamwork and Collaboration
- Focus on the Future
- People and Partners
- Creativity and Innovation
- Results and Creating Value
- Health Equity
- Public Responsibility and Citizenship

Objectives

- Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.
- Enhance public health practice-oriented education and training.
- Support the development of a diverse, highly skilled, and motivated public health workforce with the competence and tools to succeed.
- Promote and strengthen the evidence base for public health practice.

Objectives, Strategies, & Tactics

Objective A. Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.

Strategy 1: Promote development of collaborations between academia and practice within public health.

Tactics:

- a. Support the development, maintenance, and expansion of academic health department partnerships through the Academic Health Department Learning Community.
- b. Document and highlight progress being made in academic/practice collaboration within public health and the impact of that collaboration.

- c. Document contributions of Council on Linkages member organizations, individually and collectively, to improving public health performance through implementation of the Council on Linkages' Strategic Directions.
- d. Coordinate with other national initiatives, such as the Foundational Public Health Services, public health department and academic institution accreditation, Healthy People, National Consortium for Public Health Workforce Development, Public Health Workforce Interests and Needs Survey (PH WINS), and Health Impact in Five Years (HI-5) initiative, to improve public health performance through implementation of the Council on Linkages' Strategic Directions.
- e. Learn from and share with other countries and global health organizations strategies for strengthening the public health workforce.

Strategy 2: Promote development of collaborations between public health and healthcare professionals and organizations.

Tactics:

- a. Identify population health competencies aligned with the Core Competencies for Public Health Professionals that are designed for non-clinical settings.
- b. Encourage the inclusion of healthcare professionals and organizations in academic health department partnerships.
- c. Document and highlight progress being made in public health/healthcare collaboration and the impact of that collaboration.

Objective B. Enhance public health practice-oriented education and training.

Strategy 1: Develop and support the use of consensus-based competencies relevant to public health practice.

Tactics:

- a. Review the Core Competencies for Public Health Professionals every three years for possible revision.
- b. Develop and disseminate tools and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into education and training.
- c. Work with the Council on Education for Public Health to encourage use of the Core Competencies for Public Health Professionals and academic/practice partnerships by schools and programs of public health.
- d. Work with the National Board of Public Health Examiners to encourage use of the Core Competencies for Public Health Professionals in the Certified in Public Health credentialing program.
- e. Contribute to the development and measurement of Healthy People objectives related to public health infrastructure.
- f. Advance opportunities for using the Core Competencies for Public Health Professionals in the education and training of health professionals and other professionals who impact health.

Strategy 2: Encourage development of quality training for public health professionals.

Tactics:

- a. Provide resources and tools for enhancing and measuring the impact of training.
- b. Contribute to efforts to develop quality standards for public health training.
- c. Explore the desirability and feasibility of creating a process for approving and advancing training for general public health continuing education units.

Strategy 3: Promote public health practice-based learning.

Tactics:

- a. Conduct a periodic review of practice-based content in public health education.
- b. Develop tools to assist academic health departments in providing high quality practica.

Objective C. Support the development of a diverse, highly skilled, and motivated public health workforce with the competence and tools to succeed.

Strategy 1: Develop a comprehensive plan for ensuring an effective public health workforce.

Tactics:

- a. Support the use of evidence in recruitment and retention strategies for the public health workforce.
- b. Use existing data to better understand the composition and competencies of the public health workforce.
- c. Participate in the Public Health Accreditation Board's workforce development, quality improvement, and performance management activities to encourage use of Core Competencies for Public Health Professionals and academic/practice partnerships by health departments.
- d. Explore approaches for determining contributions of credentialing for ensuring a competent public health workforce.
- e. Participate in, facilitate, and/or convene efforts to develop a national strategic or action plan for public health workforce development and monitor progress.

Strategy 2: Define training and life-long learning needs of the public health workforce, identify gaps in training, and explore mechanisms to address these gaps.

Tactics:

- a. Explore emerging leadership competencies needed within the public health workforce for health systems transformation.
- b. Identify skills needed for public health professionals to assume the responsibilities of community chief health strategist.

Strategy 3: Provide access to and assistance with using tools to enhance competence.

Tactics:

- a. Develop and disseminate tools and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into practice.
- b. Assist individuals and organizations with using tools and training to implement and integrate the Core Competencies for Public Health Professionals into practice.
- c. Encourage use of the Core Competencies for Public Health Professionals as a foundation for the development of discipline-specific and interprofessional competencies.
- d. Assist with developing, refining, and implementing discipline-specific and interprofessional competencies aligned with the Core Competencies for Public Health Professionals.
- e. Assist other countries and global health organizations with developing and using public health competencies.

Strategy 4: Demonstrate the value of public health to achieving a culture of health.

Tactics:

- a. Document contributions of the various professions within public health to achieving healthy communities.
- b. Describe the unique contributions that public health professionals can bring to health systems transformation.
- c. Encourage public health professionals to engage other professions and sectors in developing strategies for achieving healthy communities.
- d. Document how public health research can and does contribute to achieving healthy communities.
- e. Participate in, facilitate, and/or conduct a profile study of the public health workforce.

Objective D. Promote and strengthen the evidence base for public health practice.

Strategy 1: Support efforts to further public health practice research, including public health systems and services research (PHSSR).

Tactics:

- a. Identify gaps in data and opportunities for improving data for conducting research relevant to practice.
- b. Identify emerging needs for public health practice research to support health systems transformation.
- c. Collaborate with other national efforts to help build capacity for and promote public health practice research.
- d. Convene potential funders to increase financial support for public health practice research.
- e. Assess progress related to public health practice research.

Strategy 2: Support the translation of research into public health practice.

Tactics:

- a. Identify ways to disseminate and improve access to evidence-based practices.
- b. Demonstrate the value of public health practice research to the practice of public health.
- c. Explore opportunities to support The Guide to Community Preventive Services.

Strategy 3: Encourage the engagement of public health practitioners in contributing to the public health evidence base.

Tactics:

- a. Develop and support implementation of an academic health department research agenda.
- b. Foster the development, sharing, and use of practice-based evidence.