



**Minutes from  
the  
April 12, 2010**

**CDC Advisory  
Committee to  
the Director**

**Release Date  
August 2010**



## Advisory Committee to the Director Record of the April 12, 2010 Meeting

The Centers for Disease Control and Prevention (CDC) held a meeting of its Advisory Committee to the Director on April 12, 2010. The agenda included reports from the Ethics and Health Disparities Subcommittees, discussion of CDC's reorganization, budget, and potentially "winnable battles," and formation of Advisory Committee to the Director workgroups to address relevant issues. No members reported any conflicts of interest. CDC Director Thomas R. Frieden, MD, MPH, welcomed the quorum of members and others attending (Attachment #1).

### **Ethics Subcommittee Report**

Chair Robert L. Hood, PhD, reported the subcommittee's charge, membership, and work focus areas for 2010. To supplement the pandemic influenza ethical guidelines, the Ethics Subcommittee crafted ethics guidelines for prioritizing the use of mechanical ventilation during a severe respiratory event with overwhelmed resources. The guidelines are designed to help agencies at all levels planning for emergencies to engage their communities, articulate the challenges and relevant points, and to be transparent about the decision criteria and who will make those decisions.

The document describes ethical points to consider when decisions must be made about allocation of scarce life saving resources during a severe pandemic. The guidelines suggest use of a multi-principle approach through use of a composite priority score that reflects the diverse moral considerations relevant to these difficult decisions. This score avoids the need to categorically deny treatment to certain groups and allows for weighting of the various ethical considerations. Public engagement and procedural justice are integral. Other considerations discussed in the document include separating clinical and triage roles, supporting uniform decisions while allowing some degree of local flexibility, and the obligations to healthcare professionals.

*Advisory Committee to the Director Comments.* CDC was advised to clearly document the guidelines' development and to gather public and professional comment (in forums or on the Web, such as <http://sermo.com>). Funding needs will be significant to get public input. The AHRQ-funded effectiveness research might serve as a model. State professional associations should be involved in this transparent development process. Consistency will be key; the guidelines' context should create uniform recommendations and state applications. However, stakeholder interests also must be considered. Routine care will not be the



standard and the private healthcare provider must be maximally supported. If local variation is permitted, clearly state in the guidelines' preamble that these are national standards that acknowledge community differences while seeking the most consistency possible.

**A motion was made** to accept the Ethics Subcommittee's document as a work in process, to be revised with a preamble including the points noted above, and with CDC seeking additional appropriate public input. **The motion unanimously passed** with no abstentions.

### **Health Disparities Subcommittee Report and CDC Update**

Health Disparities Subcommittee Chair Nisha D. Botchwey, PhD, reported on the subcommittee's multi-sectoral 2009-2010 membership, its charge, and action agenda. Their policy brief on health equities and the social determinants of health is in outline form and a draft should be ready by fall for the Advisory Committee to the Director to review. Stephen Thacker, MD, MSc, ASG/RADM (Ret.), USPHS, and Deputy Director for Surveillance, Epidemiology and Laboratory Services, reported CDC's broad examination of health disparity issues, as described by good national data. (However, a marked limitation of surveillance data on workplace hazards was noted.) A resulting CDC health disparities report, to be published in December, complements the healthcare access and quality focus of the annual *National Healthcare Disparities Report* published by the Agency for Healthcare Research and Quality. CDC's report identifies 23 areas of health with premature death and racial disparities in health outcomes, for which there is science to support their reduction through short-term (1-4 years) policies, programs, best practices and individual actions to reduce such disparities. The subcommittee suggested merging its paper into one quality document with the CDC report.

*Advisory Committee to the Director Comments.* State-level data might be available on jurisdictional differences for access to public health services and on integration of work to reduce health disparities. Data mapping to aid data presentation and categorizing the factors presented could help indicate possible intervention points. Health reform will help address disparities through its increased funding for health promotion activities; the requirement of public health agencies to have an Office of Minority Health and the creation of a National Institute for Health and Health Disparities. However, Massachusetts' experience indicates that outreach still will be needed to encourage those underserved to seek out health services.

### **CDC Director Report: Organizational Improvement**

Dr. Frieden outlined the leadership team and CDC's rapid restructuring to address his five key priorities for CDC's public health mission. Financial changes await congressional review. Organizational changes are mostly complete and are detailed later in this report.



*Advisory Committee to the Director Comments.* Since form follows function, the different skills of the leadership team will help CDC achieve the desired public health outcomes. Its new focus on policy will parallel and complement its strengths in the surveillance and epidemiology of diseases and their determinants, and in translating its own and others' excellent science. Any helpful expertise of partners in fields other than science should be leveraged. CDC communications should expand by maximizing the use of such tools as the Internet and social media.

CDC's culture must continue to support its staff's passion for public health service. This should be clearly defined and visible to existing and new employees. The members approved of a more focused component to CDC's traditional support and help to state and local public health, alongside the new national expectations on quality, coverage and healthcare technology. And, as reflected by the health disparities report, CDC will continue to be as horizontally linked as possible, within itself, within DHHS, and with public health as a whole. One example is the new monthly Public Health Grand Rounds, to share the practical application of cutting edge science with the field.

Everyone, from Congress to DHHS, to CDC itself, and the public will have to develop a different understanding of the "public" in public health and CDC's role in individual lives as well as in global diplomacy. CDC will move beyond its historic protective role to a greater understanding of health's intersection with policy and individual lives, and the parallel need for public engagement and partnership. None of this transition will be easy.

### **Health Reform and Budget Briefing**

Andrew S. Rein, MS, Associate Director for Policy, introduced CDC's work in the context of health reform and the Prevention and Public Health Fund, and Ms. Sherri Berger outlined specific aspect of CDC's budget FY2010. Attachment #2 presents some of the detailed slides.

Expanded health insurance, covering an additional 32 million people, involves mandates, Medicaid expansion and subsidies, and new state-based market systems (insurance exchanges) that will cover those with pre-existing conditions. The DHHS Secretary no longer needs congressional approval to set coverage and will design a package for Medicare, with input from the field. The new insurance regulations will emphasize patient protections, evidence-based decision making, and coverage for preventive services. Policy changes (such as menu labeling) are expected to improve health by changing consumers' knowledge and the food environment. Multiple new programs across DHHS will focus on health-related decisions at the state and local level.

The new Prevention and Public Health Fund will expand and sustain current CDC programs. From 2015-2020, annual budgets will increase from \$500 million to \$2 billion in incrementally. The intent is to improve health and restrain public/private



cost increases. Other opportunities for prevention, wellness, and public health were outlined, including the CDC-CMS initiation of reporting of healthcare-associated infections. Other areas include community transformation grants, mandated interagency cooperation on pilots, and demonstration programs. Comparative effectiveness research and research on health indicators and data on disparities will leverage CDC's expertise. New programs also are awaiting funding and should prove the value of prevention.

CDC's Financial Management Office leads the Recovery Act Implementation Office. CDC's \$1 billion allocations under this act were outlined, as were budget increases and decreases. One of the new initiatives in the FY11 request is a workforce initiative, the CDC Prevention Corps. Other new work includes funding states and communities to prevent healthcare associated infections (HAI). The Communities Putting Prevention to Work program funds proof of principle grants to demonstrate that capacity investment in prepared communities can reach the tipping point to quickly implement policies and environmental changes. Of grants to 44 implementing communities, ~67% support nutrition and obesity interventions and ~33% support tobacco control.

*Advisory Committee to the Director Comments.* Before implementing pilot projects, CDC should combine public health and actuarial research, developing a simulator for projected program savings on future healthcare costs. The incremental Prevention and Wellness Trust funding increases could plug current program funding gaps, but also offers a huge opportunity to address chronic disease and health disparities and to build local health workforces to do that. It is important that initial funding decisions may guide future allocations; CDC should be very clear that the first two years' focus should not represent ensuing work. The number of Community Health Centers is to double in the next 5-8 years, and National Health Service Corps providers will staff them. They should partner with local health departments in community health to link clinical access to companion public health interventions. CDC also should partner with other resources (e.g., private and not-for-profit players) to improve public health. The private sector's decisions on employee health could also benefit from translation of CDC's excellent science.

Novel methods of supporting prevention research and evaluation, done in other-than-RCT methods, should be explored. Optimizing information technology (IT) information about health status indicators in an integrative approach can help develop the platforms to use observational cohorts in rapid assessment (e.g., of programs/interventions). Clinical medicine is doing this now, as is FDA in its post market-surveillance. With such a framework, this initial funding could produce a robust prevention system.

In distributing the funding, one question to consider is how much science is needed before undertaking action. Sometimes, information is "insufficient for intellect but sufficient for action." Both capacity to use the funding and the political



will to support the work are considerations. Perhaps CDC should be discussing those issues with the accountable care organizations and health information exchanges. Does the public health sector have the skill and presence to be a serious participant in that? If not, how can that competence/capacity be built?

**Public comment** was solicited, and none was forthcoming.

### **Organizational Implementation of CDC Priorities**

Dr. Frieden reviewed how the five priorities would be addressed in the new CDC structure.

#### **Priority 1: Strengthen CDC's surveillance, epidemiology, and laboratory services**

*The Office of Surveillance, Epidemiology, and Laboratory Services* includes the National Center for Health Statistics and several Offices addressing: Laboratory Science, Policy and Practice; Public Health Informatics and Technology; Public Health Surveillance, Epidemiology and Analysis; and Scientific Education and Professional Development. Key priorities were presented for healthcare monitoring. Consistent definitions are needed to standardize data so as to link data for surveillance. These all involve the policy aspects of prevention, healthcare quality and safety, community health, and standards and priorities for health IT. Ideally, CDC could regularly issue data for action, drawing from medical records and surveillance data. This would essentially be a "Bureau of Health Statistics" report similar to the eagerly awaited Bureau of Labor Statistics reports on key economic indicators.

#### **Priority 2: Improve CDC's ability to support state, tribal, local and territorial public health**

*The Office of State, Tribal, Local and Territorial Support* was welcomed by the Advisory Committee to the Director and has stirred excitement in the field. It will support state and local capacity by providing resources, staff, and technical support. States' accountability will increase with stricter standards and adherence to basic criteria. This office will implement a scorecard, a consistent framework to measure outcomes, identify successes and improve public health departments' performance, and report that back to the governor and state programs. The Public Health Apprentice Program's two-year assignments will provide real-world field and policy experience. Orientation for new health officers will be provided, reviewing practice-based evidence of the strategies and evidence-base practice, and support surveillance training.

#### **Priority 3: Increase CDC's global health impact**

*The Center for Global Health* has already increased collaboration with the USAID Office of Global AIDS Coordination through weekly conference calls. Over six years, \$63 billion will help strengthen partner countries' health systems to improve health outcomes, and existing platforms such as PEPFAR will be strengthened and expanded. The Field Epidemiology Training Program's 18 resident CDC



advisors assist 13 programs in 24 countries. More than 80% of Field Epidemiology Training Program trainees stay in their country. Expansion of Field Epidemiology Training Program tracking of non-communicable disease and injuries has been piloted in China and India. The Center for Global Health helps identify risk factors/prevention strategies, supports surveillance/epidemiologic activities, helps link data to public health action and helps build national public health capacity. Methods are provided to address the five priority focus areas. The cost of not intervening will be made clear to show the value of health interventions. Finally, the Center for Global Health is working to strengthen registries in at least two African countries, including novel methods (e.g., providing a cell phone in exchange for weekly reports of health information), and evaluating strategies to link those data to maternal mortality.

“Winnable battles” in global health include substantially reducing mother-to-child HIV transmission; reducing malaria mortality and morbidity by 50% in high-burden countries; eradicating polio, eliminating lymphatic filariasis globally, and eliminating onchocerciasis in the Americas; increasing the number of trained epidemiologists to a ratio of 1 per 200,000 population and developing Field Epidemiology Training Program sites’ training tracks; and increasing global capacity to detect and control emerging threats, including non-communicable diseases.

#### **Priority 4: Increase CDC’s policy impact**

Healthcare reform involves reshaping the way healthcare is provided. CDC will contribute to health care policy development to improve Americans’ health by providing data, demonstrating prevention benefits, and helping to write the policies. CDC will support state and local policies to address and prevent the leading causes of death (tobacco control, physical activity, community access to healthy foods). It will influence federal policy beyond health reform (e.g., food policy by input to the Child Nutrition and Farm Bills), and it will influence global health policy by strengthening lab capacity and the Global AIDS Program.

#### *Advisory Committee to the Director Comments*

- Link the scorecard to the governor’s letter, accreditations and adherence standards of evidence-based policies and programs (e.g., as done by the Trust for America’s Health report for preparedness). Also report to lower levels to inform the grass roots and support health advocacy, as well as policy leaders such as corporate leaders and others who influence policy. To be fair, the scorecard will have to include the underlying characteristics of the state’s population. For example, those with minority populations will have lower scores, and health departments should not be penalized for poor performance due to legislative underfunding.
- Schools of public health may want to partner in the apprenticeship program to give their graduates good field training. Public health professionals could also be offered a year in the academic world, and the health officer orientation could include local health department directors. Beyond public



health, the opportunity to extend health communication training to the community as well (e.g., schools, students; churches, pastors).

- CDC should push for greater transparency and explain its importance to progress; for example, the role of data for action in reducing hospital acquired infection rates and that benefit to patients.
- It also is time for an ethical framework to promote a non-ideological discussion of non-communicable disease prevention (rewards, penalties, taxes, etc.).
- CDC data provide the evidence base for regulatory policy and also affect insurance coverage. To avoid unintended consequences, a thoughtful review is warranted of its project grants, surveillance and regulatory work that bear directly on clinical care.
- Health reform presents an opportunity to educate people on what CDC contributes and to enhance continued support (e.g., CDC's participation in the First Lady's prioritization of obesity prevention and its *Healthy People* initiative work to advance tracking the nation's health).
- CDC's provision of its raw data to accompany these reports, as possible and appropriate, can be helpful to extend that analytic capability for others' use, although this would require some revision in CDC culture. The Institute of Medicine's vaccine safety report indicates the changing and growing needs for such sharing. California's Health Information System is a relevant model for this.

## Advisory Committee to the Director Workgroups Discussion

### State and Local Workgroup

Chair Dr. David Fleming; Members: Dr. Hood, Dr. Baird, Dr. Farley, Dr. Bal

This group will work to integrate CDC's and state and local health departments' work, explore best practices, and encourage better communication and use of IT. Using frameworks such as the ISOs to measure the scorecard components was suggested, or creation of a hybrid of that framework, which could allow comparison of best practices and become a standard across the field. Other ideas discussed included tapping the expertise of retired public health officials; exploring the workplace intangibles that attract people to certain health departments; reassuring state and local agencies that the "scorecard" is a positive tool (e.g., to help gain resources to address identified weaknesses); and suggesting other partners beyond schools of public health that might help maximize local areas' resources, particularly in workforce development. Importantly, the workgroup will consider how best to frame the issuance and use of the funding, and prove it is well spent, as a key part of what needs to happen over the next couple of years.



Surveillance and Epidemiology Workgroup

Chair Dr. Kelly Henning, Member: Dr. Delbanco

This group will consider the existing data and how to better package it to inform policy, as well as additional data sources or development of new data systems, particularly with healthcare reform. The scope will be narrowed in consultation with Public Health Surveillance Program Office Acting Director, Dr. James W. Buehler. Advisory Committee to the Director comments included that, most likely, only DHHS will be able to link registries' and electronic medical records data. Exploration of new technologies to get health messages to the public (e.g., an iPhone app) was suggested. This workgroup should coordinate with the state and local workgroup to address overlaps, such as the health reform legislation's inclusion of national wellbeing indicators. Coordination also can address the current gap in tools/facilities and training to use the data, or even to understand the indicators and their implications. Developing ways to build on the resources at state and local level would be valuable.

Global Health Workgroup

Chair Dr. Alan Greenberg; Members: Dr. Seffrin, Dr. Sullivan, Dr. Henning, Ms. Kelly, Dr. Fleming (Dr. Bal initially joined but then offered to withdraw to work on the Policy Workgroup.)

This workgroup will discuss leadership issues, integration of programs that have not worked well together to date, the Center for Global Health's relationship to its natural partners (i.e., the U.S. and host governments) and how lessons learned abroad and domestically can inform each other. The members will define their topics of address. Dr. Frieden hoped that Advisory Committee to the Director subsets could serve as "incubators" or feedback loops for the Center for Global Health. Given the center's newness, the group may need to think "out of the box." To facilitate that, particularly with regard to innovation and new technologies, the Advisory Committee to the Director members suggested leveraging their expertise (and that of other-than-public health partners, such as business and foundations) for CDC staff around the world. Other suggestions were that the workgroup consider financing issues to help CDC get past its reputation for categorically-funded priorities to a more cross-cultural focus.

Policy Workgroup

Chair Dr. Sara Rosenbaum; Members: Dr. Bal, Dr. Sanchez, Ms. Lappin, Mr. Wheeler, Dr. Botchwey

The Advisory Committee to the Director members formed this workgroup to help CDC participate in health policy, whose timely issues are not historically a CDC strength. The rapid movement of health reform likely would be the initial charge, followed by other pressing but indirectly linked areas. Dr. Frieden requested input



on how CDC can be more effective on a policy front, since that participation is resisted in many quarters.

The workgroups were advised to coordinate as appropriate with the National Biosurveillance Advisory Subcommittee. Dr. Frieden pledged CDC's support to their work. He encouraged them to schedule informal teleconferences and other communications as needed. Drs. Sanchez and Sullivan will collaborate to plan a teleconference with past Advisory Committee to the Director Chairs to discuss their methods.

**Priority Five: Better prevent illness, disability and death**

**Winnable Battles.** Ileana Arias, PhD, CDC Principal Deputy Director, reaffirmed the CDC's prime motivation to meet its mandate to prevent death, illness and disability, and to improve Americans' health and quality of life. The five broad priorities affect every program, to allow focus on what needs the most attention. If some problems are scalable and can be solved by other-than-traditional, but effective, approaches, then those approaches should be done. Those successes then can be used to build support for work in other areas of fewer resources.

CDC selected six focus areas of "winnable battles," based on the basis of their burden to Americans' health, the available evidence base; the social and political will to address them, and partnerships to help reach success; tobacco; healthcare-associated infections; motor vehicle injury; teen pregnancy prevention; and HIV prevention. Dr. Arias outlined the burden for each and the possible interventions (Attachment 3).

*Next steps.* CDC will implement the plans developed and do quarterly assessments of their progress toward anticipated outcomes, then "celebrate or adjust." Each intervention strategy linked to the five priorities includes identifying related health inequities, which each program will address and monitor. Strategies and initiatives will be evaluated.

*Advisory Committee to the Director Comments.* Except for healthcare-associated infections, all of these are core public health priorities for preventable hospitalizations. The wish was voiced for more of a "health value" focus in healthcare reform than seen to date (e.g., interventions of aspirin, blood pressure, cholesterol control, and smoking cessation — the ABCs). CDC will address whatever it can directly influence, and it is hoped gaining agreement on a short list to make the biggest difference in terms of health outcomes. CDC again was urged to maximize partnerships, such as collaboration with the Centers for Medicare and Medicaid Services to push awareness of and address health problems that both agencies address.

The Advisory Committee to the Director agreed that the timing seemed right for a number of these winnable battles, but these battles will require collaboration and integration across programs. Links between public health, healthcare and



healthcare reform were noted. For HIV, links are seen in the easily available rapid test for HIV and the data on the effectiveness of the new NIH guidelines to treat regardless of CD4 count. In particular, CDC can stress prevention among HIV-positive individuals, and its influence with the Health Resources and Services Administration could help to further advance local-level prevention counseling.

Despite alcohol screening's proven high impact and cost effectiveness, clinicians are not doing screening for alcohol. Prevention of both alcohol abuse and tobacco use can link clinical practice and public health. The challenge is to move such practices into widespread implementation. One way CDC could fill the national primary prevention gap for drug and alcohol abuse mortality could be to disseminate some state health departments' successful alcohol/drug prevention program components. Solving the translational issue could be CDC's most difficult task; for example, tobacco intervention efforts nationwide are "an inch deep and a mile wide."

Motor vehicle injury prevention relates to the environment because most trips to work or school involve only 1-3 miles. It may be easier for CDC to focus on getting people out of their cars to decrease crashes injuries/deaths, than to influence drivers' license or impaired driving policies. The important question was raised of how many of the priorities are funded, and the way policy straddles all of them was noted. Rather than epidemiologic science, it is "spin" that moves policy. Making raw data widely available is a double-edged sword; those data can be used to promote health advocacy (e.g., by communities without public smoking ordinances), but also for reverse intents.

### **Closing Comments**

Certificates of appreciation were given to the Advisory Committee to the Director members who have led the Subcommittees and provided their unique and valuable perspectives: Mr. Collar, Ms. Berryhill, Ms. Lappin, Dr. Nelson, and Dr. Sullivan. Dr. Sanchez thanked Ms. Gayle Hickman and CDC staff for facilitating the meeting logistics, and the CDC staff for attending and presenting. He particularly thanked the members rotating off who will still participate in the ACD workgroups.

The members appreciated the meeting's in-depth discussions, despite the rushed agenda, and encouraged Dr. Frieden to contact them as needed between the meetings. They endorsed CDC's injection of health into almost all policy and urged the agency to seize the opportunity of health reform. One area still needing discussion is workforce development to provide the needed health services—something for the Health Resources and Services Administration and Congress, as well as CDC, to address. CDC's work with partners to advance the nation's health, focusing on the winnable battles and the best evidence to do so, was strongly supported. The resulting evidence will provide a powerful message of what will happen with intervention, and what will happen in its absence and gain support.



**Public comment** was again solicited, to no response. A **motion to adjourn** was made and passed unanimously, with no abstentions. The next meeting will be on October 28, 2010, and the workgroups will communicate until then. One organizational meeting to establish a common understanding among the workgroups will be held.

**CERTIFICATION**

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 12, 2010, meeting of the Advisory Committee to the Director, CDC are accurate and complete.

8/6/2010

Date

EJ Sanchez MD

Eduardo J. Sanchez, MD, MPH, FAAFP  
Chair, Advisory Committee to the  
Director, CDC



**Attachment #1: Attendance**

**ACD Members Present**

**James Nicholson (Nick), Baird, Jr., MD**  
CEO, Alliance to Make US Healthiest and  
President, Stillwater Solutions, LLC

**Dileep G. Bal, MD, MS, MPH**  
Kauai District Health Officer  
Island of Kauai, Hawaii

**Vivian Berryhill** (by telephone link)  
President and Founder  
National Coalition of Pastors' Spouses

**Nisha D. Botchwey, PhD**  
Associate Professor of Urban and Environmental Planning and Public Health  
Sciences, School of Architecture, University of Virginia

**Sanford R. Climan, MBA, MS**  
President, Entertainment Media Ventures

**Mark A. Collar**  
Partner, Triathlon Medical Ventures

**Suzanne Frances Delbanco, PhD**  
President, Health Care Division  
Arrowsight, Inc.

**Thomas A. Farley, MD, MPH**  
Commissioner  
New York City Department of Health and Mental Hygiene

**David W. Fleming, MD**  
Director and Health Officer for Public Health  
Seattle and King County

**Alan E. Greenberg, MD, MPH**  
Professor and Chair  
Department of Epidemiology and Biostatistics  
School of Public Health and Health Sciences  
George Washington University



**Kelly J. Henning, MD**

Director, International Health Programs  
Bloomberg Foundation

**Mary Kelly**

Executive Vice President  
Merchandising and Category Management  
Shoppers Drug Mart

**Debra R. Lappin, JD**

Senior Vice President  
B & D Consulting, LLC

**Jonathan T. Lord, MD**

Chairman  
Dexcom, Inc.

**Kenneth D. Mandl, MD, MPH**

Associate Professor, Harvard Medical School and  
Director, Intelligent Health Laboratory, Children's Hospital Informatics Program  
Children's Hospital, Boston

**Sara Rosenbaum, JD**

Harold and Jane Hirsh Professor of Health Law and Policy and Chair  
School of Public Health and Health Sciences  
George Washington University Medical Center

**Eduardo J. Sanchez, MD, MPH, FAAFP**

Vice President and Chief Medical Officer  
Blue Cross and Blue Shield of Texas

**John R. Seffrin, PhD**

Chief Executive Officer  
American Cancer Society

**The Honorable Louis W. Sullivan, MD**

President Emeritus  
Morehouse School of Medicine

**M. Cass Wheeler**

Strategic Consultant/Coach/Speaker  
Former Chief Executive Officer  
American Heart Association, Inc.



**ACD Member Absent:**

**Thomas C. Nelson, PhD**

Chief Operating Office  
American Association of Retired Persons

**CDC Staff Attending:**

**Ileana Arias, PhD**

Principal Deputy Director, CDC  
Principal Deputy Administrator  
Agency for Toxic Substances and Disease Registry

**Lynn Austin, PhD**

Deputy Director for Operations  
Office of Public Health Preparedness and Response

**Drue Barrett, PhD**

Public Health Ethics Coordinator  
Office of the Chief Science Officer  
Office of the Director  
Designated Federal Officer, Ethics Subcommittee

**Ursula Bauer, PhD, MPH**

Director  
National Center for Chronic Disease Prevention and Health Promotion

**Sherri Berger, MSPH**

Office of Formulation, Evaluation and Analysis  
Financial Management Office

**Mark Biagioni, MPA**

Public Health Analyst  
Office of the Principal Deputy Director

**Janet Collins, PhD**

Associate Director for Program  
Office of the Director

**Henry Falk, MD, MPH**

Acting Director  
National Center for Environmental Health/Agency for Toxic Substances and  
Disease Registry, CDC



**Kevin Fenton, MD, PhD, FFPH**

Director

National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

**Thomas R. Frieden, MD, MPH**

Director, CDC

Administrator, ATSDR

**Donna Garland, BA**

Associate Director for Communication

Office of the Director

**Anne C. Haddix, PhD**

Acting Director

Policy Research, Analysis, and Development Office

Office of the Director, CDC

**Thomas Hearn, PhD**

Acting Director

National Center for Emerging and Zoonotic Infectious Diseases

**Gayle J. Hickman**

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Deputy Director for Infectious Diseases

**Lore Jackson Lee, BA, MPH**

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**Edward J. Sondik, PhD**

Director  
National Center for Health Statistics

**Stephen B. Thacker, MD, MSc, ASG/RADM (Ret.), USPHS**

Deputy Director  
Surveillance, Epidemiology, and Laboratory Services

**Edwin Trevathan, MD, MPH**

Director  
National Center for Birth Defects and Developmental Disabilities

**Walter W. Williams, MD, MPH**

Director  
Office of Minority Health and Health Disparities  
Office of the Associate Director for Program  
Designated Federal Officer, Health Disparities Subcommittee



General Public

**Charles Stokes**

President and CEO  
CDC Foundation

**Chloe Knight Tonney**

Vice President for Advancement  
CDC Foundation



## Attachment #2: CDC Budget Aspects

### Prevention and Public Health Fund

- Expand and sustain national investment in prevention and public health programs
- Grows from \$500m to \$2b annually

2010	2011	2012	2013	2014	2015 to 2019
\$500 million	\$750 million	\$1 billion	\$1.25 billion	\$1.5 billion	\$2 billion/year

- Improve health and help restrain the rate of growth in private and public sector health care costs
- Prevention, wellness, and public health activities including
  - Prevention research
  - Health screenings
  - Immunization

### CDC Recovery Act Funding

PROGRAM	ALLOCATION
Section 317 Immunization	\$300,000,000
Information Technology Security*	\$24,163,907
Healthcare Associated Infections	\$40,000,000
Comparative Effectiveness Research*	\$30,450,000
Communities Putting Prevention to Work	\$607,500,000
Health Information Technology*	\$30,575,000
<b>TOTAL</b>	<b>\$1,032,688,907</b>

\* Funds managed by the Department of Health and Human Services

### Section 317: Program Highlights

- Vaccine purchase (\$167M)
- Pilot program: billing private insurance for immunization services provided to plan members (\$6M)
- States and territories for operations (\$81M)
- Improving the interoperability of Immunization Registries (\$11M plus \$15M of HITECH funds)
- Education and Communication (\$9M)

### CPPW: Program Highlights

- National Organizations Initiative = \$10M (posted March '10)
- AoA's Chronic Disease Self-Management Program = \$32M (award Apr '10)
- State/Territory Policy and Environmental Change (base/competitive funding) = \$75M (awarded Jan-Feb '10)
- Tobacco Quitlines = \$50M (awarded Jan-Feb '10)

### CPPW: Program Highlights

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### FY 2010 to FY 2011: Budget Highlights

DESCRIPTION	FY 2010	FY 2011	DIFFEREN
BUDGET AUTHORITY	\$6.4B	\$6.3B	-\$132M
ATSDR	\$76M	\$76M	-
PHS EVALUATION	\$352.4M	\$345.7M	-\$6.7M
VACCINES FOR	\$3.64B	\$3.65B	+\$15M
EMERG.	\$0	\$224.9M	+\$224.9M
<b>TOTAL OPERATING BUDGET</b>	<b>\$10.52B</b>	<b>\$10.62B</b>	<b>+\$100M</b>

### FY 2011 Request: New Initiatives

DESCRIPTION	AMOUN
BIG CITIES INITIATIVE	\$20M
GLOBAL SAFE WATER	\$10M
CDC PREVENTION CORPS	\$10M
BUILT ENVIRONMENT HEALTH INITIATIVE	\$4M
GLOBAL MATERNAL, NEWBORN AND CHILD	\$2M

### FY 2011 Request: Key Decreases

Description	Decrease
AGENCY-WIDE CONTRACT AND TRAVEL REDUCTION	-\$100M
BUILDINGS AND FACILITIES	-\$69.2M
VECTOR-BORNE SURVEILLANCE	-\$26.7M
CONGRESSIONAL PROJECTS	-\$20.6M
317 IMMUNIZATION -	-\$13.4M
ANTHRAX	-\$9.2M
ANTIMICROBIAL RESISTANCE	-\$8.6M

### Attachment #3: Winnable Battles

*Tobacco* is the leading preventable cause of death in the United States and offers the largest potential public health impact. Tobacco use costs tens of billions of dollars in medical expenses and lost productivity. Second-hand smoke exposure is still an issue among 45% of non-smoking Americans with measurable cotinine levels. Interventions include increased excise taxes, promotion of smoke-free environments, media outreach, and CDC assistance to FDA regulation development.

*Nutrition, physical activity, obesity, and food safety.* Obesity has doubled among adults and tripled among children in the last 20 years. Annual mortality could be reduced by 200,000 deaths with sodium reduction and by the tens of thousands with elimination of artificial trans fats. Interventions include changing the environment to promote healthy food and active living, improving foodborne illness detection and quick response, and preventing future foodborne outbreaks.

*Healthcare-associated infections (HAIs)* cause 99,000 annual deaths, cost \$26-33 billion in excess medical costs, and sicken one in 20 patients in U.S. hospitals. The dollar and human costs from infections in the blood stream, urinary tract and surgical sites are all preventable. Interventions: Strengthen national surveillance through the National Healthcare Safety Network; do public data reporting and provide data for action; increase hospitals' implementation of evidence-based prevention guidelines; and encourage policies that reimburse for prevention activities.

*Motor vehicle injury* is the leading preventable cause of 45,000 deaths among youth annually, and 4 million emergency department visits. Teen crashes cost \$40 billion annually, including their long-term consequences. Interventions: Strong graduated drivers license policies save 250,000 non-fatal injuries and 175 deaths annually, and reductions in impaired driving produce 9,000 fewer fatalities. For every dollar spent on alcohol ignition interlocks, almost \$7 is saved. However, this is likely to be as controversial an intervention as was the seat belt mandate.

*Teen pregnancy prevention.* Two-thirds of the pregnancies among women aged <18 years are unintended. Those pregnancies increase the likelihood of infant death, low-birth weight and preterm birth. They increase healthcare costs and perpetuates a cycle of poverty through social, occupational and economic impacts. Interventions: Increase access to longer-acting reversible contraceptives, improve reimbursement policies to cover teenagers' family planning needs, and work to change social norms.

*HIV prevention.* An estimated 1.1 million Americans have HIV, 20% of whom are unaware of their infection. The rates of unsafe sex are increasing, along with syphilis and HIV, among young men who have sex with men. They are 50 times more likely to be infected than other men. Interventions: Increase awareness of HIV status, improve linkage to care, support prevention programs among those who are HIV-positive, and expand prevention programs to reduce risky behaviors.

