

Centers for Disease Control and Prevention

Advisory Committee to the Director

Summary Minutes of the February 5, 2004 Meeting

**Meeting Held at the CDC Headquarters
Atlanta, Georgia**

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Summary Minutes of the February 5, 2004 Meeting

A meeting of the Advisory Committee to the Director (ACD) of the Centers for Disease Control and Prevention (CDC) was held on February 5, 2004, at the CDC headquarters in Atlanta, Georgia. The meeting was convened at 8:40 a.m. by Committee's Executive Secretary Mr. Robert Delaney.

Attendance. All the members of the committee attended with the exception of the Chair, Dr. John O. Agwunobi. As Florida's health officer, he was prevented from attending due to his responsibility to conduct a major terrorism response exercise. Since the focus of this meeting was on CDC's Futures Initiative, the committee members were joined by the Chairs of all of CDC's other advisory committees. The meeting material included biographies of the committee members and of CDC's senior leadership, summary minutes of the July 2003 ACD meeting, and preliminary summaries of the four CDC strategic planning workgroups.

AGENDA

The members and committee Chairs introduced themselves and their affiliations (see Attachment #1). An **Overview of the Federal Advisory Committee Act (FACA)** was provided by Ms. Sheryl L. Gagnon, of the CDC Management, Analysis and Services Offices (MASO). She defined FACA's purpose, applicability to advisory groups, and distinguished the roles of subcommittees and workgroups. CDC's routes of communication from the congressional level to that of the workgroups were charted. Also described were the committee's governing authorities, this committee's charter, FACA requirements (basic, financial/conflict of interest, ethical), and the roles of the Designated Federal Official (DFO)/Executive Secretary (Mr. Delaney), the Chair, and the members. The charter of the ACD, which is a discretionary committee, was recently renewed to 2006.

An Update by the CDC Director, Dr. Julie Gerberding, described CDC's current strategic planning process. A "State of CDC" report, never done before, was provided to the members. Reflecting CDC's new macro approach, it described CDC's *collective* performance for the last year, a departure from previous years' focus on its individual Centers, Institutes, and Offices. The members' feedback was solicited. The report's three themes delineated CDC's major activities; modernizing public health and CDC's role, preparing for threats at home and abroad, and protecting people's health across all life stages. These are pursued through:

1. Expanded health protection research to inform the science: This will be scientifically credible, integrated with the NIH agenda, relevant to the nation's needs, and prioritized and focused. Both intramural and extramural research will be peer-reviewed. Successful research to date include CDC's response to the West Nile Virus, encompassing WNV's epidemiology across species, risk factors for severe disease, development/deployment of rapid diagnostic tests to U.S. blood banks, and demonstration of the worth of vector

control programs.

2. Community based participatory health protection research: This seeks to translate the science into best practices for application among targeted and new populations. This is external, peer-reviewed work, to: address disparities in health screening, improve school children's food choices, increase the time before adolescents' sexual debut, promote early autism detection, and communicate health messages to youth. About 400 letters of intent were received for this program, but only ~26 could be funded.
3. Protection against health threats with local impacts on health, the economy, and global security (e.g. SARS): The response capacity must be quick to detect, apply the science, quickly and effectively communicate the threat, and integrate response to it across disciplines (e.g., zoonotic outbreak response with the veterinary community) and foreign health ministries. Global connectivity, collaboration, and speed of response are paramount.
4. All-hazards preparedness: This goes beyond infectious disease to include terrorism response. Congress' investments to support science at CDC is being extended, as much as possible, across the public health system (e.g., Chicago's improved response to a meningitis outbreak, and Pennsylvania's to a hepatitis A outbreak from green onions).
 - The Smallpox Preparedness Program demonstrates the nation's ability to quickly prepare for cross-jurisdictional response capacity. But public health is only as strong as its weakest link. The communication challenge lies in the fact that preparedness is a process, not an event. The SPP is an indicator; jurisdictions able to handle a smallpox attack could probably handle anything.
 - To speed communication, cross-agency input to the Public Health Information Network (PHIN) is being pursued, with a platform based on state of the art standards of information technology. The BioSense System (biologic surveillance) will move beyond fax/phone communication and enable the assembly of public health information nationally (e.g., prescriptions, food borne outbreaks, hospital data).
 - Similarly, CDC's Emergency Communications Center system, toured on the previous day, uses very sophisticated communication equipment to allow rapid cross-agency communication and decision making (e.g., FBI, DHS, FDA, etc.) that is based on good data.
5. Protection of people from chronic disease, injury and disabilities in all life stages (the latter is the new framework): In the U.S. and world-wide, unintentional injury among children (mortality of 12/100,000 U.S. children in 2000) is a critical issue addressed by the NCIPC. The NCBDDD has translated scientific understanding of folic acid to prevent birth defects. NCEH/ATSDR's work with NCHS to demonstrate declining blood lead levels showed how policy changes (to unleaded gas) can significantly improve national health. CDC will be the first federal agency to have a smoke free campus; other public health anti-smoking campaigns have contributed to the decline of youth smoking. Obesity is now the #1 health threat in the U.S. This was shockingly conveyed by the progressive mapping of obesity rates (BMI ≥ 30 or ~ 30 lbs overweight for a 5'4" woman) in the U.S. from 1985 to 2002. In 2002, more than half the states had populations that were 20-24% of their population obese, and in three, >25% were. Children are

developing obesity and diabetes at accelerated rates; many children now have at least two risk factors for coronary disease and heart attack. Such health outcomes reflect the interaction of genetics, the environment, and behavior.

CDC participated in a DHHS retreat that discussed the implementation of the new legislated Medicare reform this year. A high priority is to ensure the inclusion of disease prevention for seniors in that reform. The 23 awardees of the STEPS to a Healthier U.S. program were mapped, to provide tools to help local public health organizations improve the nation's health. The public's new awareness of public health and the administration's support provides an exciting window of opportunity in health. But change is necessary to truly improve the nation's health, and the Futures Initiative is designed to lead CDC in that direction.

In discussion, CDC's role in the President's \$15 million Emergency Fund to Prevent AIDS Internationally was outlined. Dr. Gerberding described a trip to Africa by national and international health leaders last year. They were universally impressed with what can be accomplished with few resources. For example, CD4 counts were raised through a simple home based treatment that began with clean water and TB treatment, continued with pill taking education and progressed through to an antiretroviral drug regimen.

Dr. Gerberding closed with a quote from Hippocrates, that "The function of developing and protecting health must rank even above that of restoring it when it is impaired." She also asked the committee for a "sound bite" to explain what public health is to the American public. Conveying this clearly and succinctly is a fundamental problem. Later in the meeting, she listed the responses (see Attachment #2).

The **CDC Facility/Budget Update** was provided by Chief Operating Officer Mr. William Gimson. CDC's abysmal *Facilities*, "...many of them makeshift.... firetraps, expensive to maintain, and biologically unsafe" (written in the 1950s, but still true in the 1990s) have been funded for upgrades. Of CDC staff, ~70% work in 30 leased buildings, costing \$35 million/year. The rest work on three Atlanta campuses: Lawrenceville (90 acres), Chamblee (50 acres, 8% of staff), and Roybal (headquarters, 25% of staff) 50 acres. The interesting history of each campus was outlined.

After 9/11 and the exponential increase in CDC's responsibilities, the previously ad-hoc approach to building facilities ended. With congressional funding and the help of Atlanta businesses (e.g., Home Depot, UPS, Delta airlines, BellSouth, etc.), a ten-year plan was developed to construct 13 new buildings (47% laboratory; 53% research support) to house ~6,200 employees in 2.9 million square feet. About half will be done within 18 months:

- The Central Facilities for Roybal (completed in 2003) and Chamblee (2003) campuses will power them for 7-10 days.
- Chamblee's environmental toxicology lab of 150,000 square feet will house 160 scientists (2005).
- Roybal's 500,000 square-foot infectious disease Biosafety Level 4 lab (2005) will enable work to continue while the other, original, suites are decontaminated.

- The 12-story, 336,000 square-foot Emergency Operation Center and headquarters building (2005) will have two auditoriums for training as well as state of the art broadcast facilities for distance learning.
- A Trans-Shipment Center will off-load trucks away from the central campus.

Projects remaining include three research support facilities at Chamblee and one east campus lab consolidation project. Eighteen months ago, the accounting firm KPMG analyzed the lease costs versus built facilities and estimated a net savings of \$250 million from staff consolidation on campus.

Budget. The CDC Website provides the FY04 and FY05 budgets in detail (See Attachment #3). The FY2004 appropriation was signed on January 23, 2004 . It provided an increase of \$132 million from 2003, which was divided between several areas. This year is the first time that funding to CDC has included non-categorical funding for global disease detection and for public health research (which differs from prevention research). This budget includes the largest increase ever given to improve health status data collection. The decreased funding for immunization was balanced by the increase in the VFC appropriation and by OMB's approval of \$40 million to create an influenza vaccine stockpile in 2004-05.

Discussion included that none of these figures included transferred funds from the Department of Energy. Dr. Bond stated the ATSDR Board of Scientific Counselors' disapproval of the building budget cut. In other comments, Mr. Gimson reported that the third of the billion-dollar bioterrorism budget was going to the states. Some has been moved to bioterrorism surveillance; some will go to states and local areas. Dr. Sundwall recommended more collaboration with the private sector to complement and support the public health laboratories. The decreased budget for the VERB program will require reassessment of the whole project since it will be funded at such a low level. However, the preliminary data indicate that its approach was far more effective than expected. The data were presented later in the meeting.

Finally, the committee was told of how, when the December orange alert led to realization of the need for an alternate operations center away from the Roybal campus, an offsite area of bare concrete and pits was transformed in 100 hours to a furnished, ready backup space. This was all done by contractors and >200 CDC staff, who worked during vacations, past retirement, etc.; another example of the CDC's esprit de corps. It functions so well that it was decided to retain this facility and scrap plans for another one that was designed – at a saving of \$5.5 million.

Dr. Gerberding provided an **Update and Overview of the CDC Futures Initiative**, which has been underway for the past six months. In a world of globalization, connectivity/speed, cost effectiveness and accountability are required for success. CDC now works in a environment of pressure upon health, sharing with healthcare delivery and the business sector, the rising costs of service delivery and changing population demographics (aging and diversifying population). But there are also enormous opportunities: new science, solutions, and a sophisticated population who will contribute to decisions about their own health status.

This process is outside-in, interactive, driven by data, and focused on customers. The first work was on strategic direction, then on structure and processes. In an internal poll, 80% of staff acknowledged that the organization had to change/evolve. National and international friends and critics were also surveyed. The process has four phases: 1) input; 2) ideas (developing plans for action); 3) implementation; and 4) impact (overall plan for action).

Futures Initiative Consultant Report. Mr. Jim Down, Sr., a retired vice chair of Mercer Management and Consulting, served as advisor/consultant to CDC in this process. CDC was referred to him by Mr. Oz Nelson, former CEO of UPS, who now Chairs the CDC Foundation Board. Dr. Gerberding asked his help in identifying what CDC, a strong organization, does well, less well, and how it could be transformed to make a significant impact on health. What was desired was not just a public health model, but a model of organizational change.

Mr. Down reported the key findings gleaned from focus groups held with segmented groups of the "customers" needing the health impact (e.g., the public, healthcare delivery systems personnel). He conducted interviews (most in person, some by phone) with traditional partners (state/local health department and business, interest groups who were dissatisfied with CDC in the past, faith-based groups, etc.).

Key strengths consistently identified, and critical building blocks, included CDC's unparalleled reputation of infectious disease expertise. Its scientific capabilities prompted great trust. The science was seen as not impacted by politics, and it is extremely important that this continue. CDC's "SWAT team capabilities" and resources to answer health needs world-wide are known, and it has an impressive work force (talented and dedicated). It has a mission-driven culture and esprit de corps rarely seen, and its brand is rarely achieved in business – the best in the world.

But *weaknesses* often cited included:

1. Autonomous and uncoordinated "silo" sub-parts in the CDC organization. This produced confusion among customers/partners, who greatly desired coordination to radically improve its effectiveness.
2. Poor listening skills; the word "arrogant" was used surprisingly often about CDC as an *organization*. It was seen as paternalistic rather than as a partner.
3. Universal lack of knowledge about CDC, even among healthcare professionals. Businesses struggling with rising health costs had no concept of how CDC could help. Public health was better informed, but still lacked an overall concept. There was no perceived coordinated approach to healthcare. These are significant issues and an opportunity.
4. Information systems are seen as good or progressing, but again apparently neither coordinated nor market tested. Some reported receiving conflicting messages.
5. Many familiar with CDC commented that it focuses on and emphasizes process rather than impact, an important finding that CDC needs to take to heart.
6. Most local health departments felt that CDC focuses almost exclusively on the states, and some of these are larger than many of the states. Both should be dealt with simultaneously.

Recommendations; CDC should:

1. Lead in the area of prevention, "put it on the map;" it could make a big difference.
2. The (vaguely defined) public health system wished for greater leadership and collaboration, for example, to establish standards that would actually create a "system." But the very idea of CDC developing and delivering these in the traditional, paternalistic manner was "dead on arrival." CDC should use its influence more to set agendas; use its brand.
3. Translate the research to something practical and useful in the field. Do not assume that the communication is always to a scientist.
4. Communication was seen as improved by some (Dr. Gerberding often was credited) but not yet a strength. Getting information out in a clear and timely way is a big opportunity both externally and internally. The "State of CDC" report is good start.

Mr. Down summarized that CDC had come a long way in six months in thinking about its customers and partners. New technologies provide many different ways to reach people and affect health, well beyond the old paths. The outside-in approach should be ongoing, both formally and informally, providing constant contact to see how the organization is doing and what it could be doing better.

Dr. Gerberding summarized the four workgroups working as the "incubators" for the Futures Initiative: Global Health, Health Systems, Public Health Research, and the Customers, Partners and Channels Workgroups. They know that CDC's brand is strong, especially for infectious disease, but there is a disconnect between the customers' top health concerns and their perceptions of CDC. CDC needs to strengthen its leadership role in establishing a health protection agenda and defining health priorities, with a focus on people in all life stages. It needs to package its work in ways that are meaningful to people (e.g., having on the Website what children, adults, seniors need to know); partner with businesses, schools, faith-based and healthcare organizations, to reach the populations hardest hit by health disparities; and improve its interaction with national, community-based, and minority organizations to better reach priority populations.

With that in mind, CDC needs to set about creating a strong governmental public health system, which is the backbone of everything else. This is not just issuing reports and diagnosing problems, but really *leading*. It needs to expand its marketing and communication capabilities to target people, not diseases, to eradicate its past "silo" mentality to achieve synergy, and to expand the knowledge base through research.

Internally, it needs to reinvent how CDC operates to improve impact. In the next six months, CDC's council of top managers will define the highest priority changes needed to increase external success. A CDC structure will be developed that supports the goals and priorities in a more integrated manner.

A flow chart was shared of how people move from a state of health to a state of disease. Healthy

people become vulnerable because they are exposed to something or because they choose a risk behavior, become diseased and enter the care system. In the U.S., 97% of the dollars spent on health is for care; <3% of the budget is spent on keeping people healthy. The concept of health protection prevents the entry into care. This suggests that CDC should be redefined not as a disease control agency, but a health protection agency, providing the knowledge and tools to support the population's health and healthy choices. Such considerations as the role of safe communities as related to maximum life expectancy raises a new dimension that prompts transformational thinking.

Health protection is accomplished through: 1) preparedness for infectious diseases and terrorism threats; 2) health promotion and prevention of disease, disability and injury in all life stages. In the context of choosing health (not "making you healthy"), several things are needed for either individuals or the agents that support health choices (e.g. policies, insurance, etc.): a population that wants health and values it beyond disease care/reversal of consequences of poor health decisions, one that has hope (e.g., by teens for a better life) and one that is aware, that "knows health," and is aware of health choices and consequences at the societal and individual level. Health needs to be accessed, not just by healthcare delivery, but through information and support systems to make these decisions. The choice is to *act*: to behave, as an individual or organization, in a way that will achieve health.

NCHS health assessment data and CDC's customer research provide the starting point for R&D to fill the knowledge gaps, tools to address those health issues, and evaluation of their efficacy, in coordination with others doing similar work, such as NIH. The packaging/marketing of this will be segmented by life stage to assemble programs/tools that address specific populations (children, urban, or urban-Spanish speaking, etc.). This will require more sophistication than the traditional publication of materials, journal articles, etc. Tools that people can use are needed, to show the value of what CDC has to offer and to "sell" it. Customers in possession of the right knowledge will use those tools and health will be improved.

Dr. Gerberding concluded that, to get there, CDC needs to provide leadership and ensure that its partners and agents agree and will help to achieve these goals. success must be measured in terms of the goals of health impact, R&D, and organizational aspects. That could be the hardest part, as people are not yet used to this; but the next "State of CDC" report will include evaluation of how CDC is leading, managing, and using its resources. But "change is a process, not an event." CDC will continue to solicit input and generate ideas, to articulate and "advertise" CDC's goals and strategies, to implement actions to address new strategies and then to measure the impact.

Committee Response included frequent commendations of CDC for this very healthy change initiative. It was expected to greatly improve the future of this "national treasure" by focusing on its areas of excellence. CDC cannot be all things to all people, but its future shape is emerging. Comments included:

- (Mr. Lerner) Develop an online "CDC Newsletter;" (Mr. Down) or a CDC health column to all businesses for automatic insertion in their newsletter

- (Dr. Lappin) Take the opportunity to be a model of how interdisciplinary science should be conducted; a visible demonstration of CDC translates NIH's scientific work into application. The ongoing CDC/NIH directors meetings are a good step in this direction. In other examples, CMS is delaying Medicare program plans pending a "virtual Center" that will apply CDC research for better health and fast track it to CMS policies; FDA and CDC are developing a joint safety information system. But only one of the challenges to such seamless and productive coordination is categorical congressional funding (e.g., not only to CDC, but also to separate NIH institutes rather than to NIH overall).
- (Dr. Caldwell) Part of the reason CDC is so well recognized for its expertise in infectious disease is that this is what is on the TV news. Injury and chronic disease prevention need to be advanced as a group to gain media attention as well. There is no easy way to do that; ricin is a more exciting topic than chronic disease. But there have been some wins, such as the attention to obesity since NCCDPHP found such graphic ways to demonstrate its spread in the U.S.
- (Mr. Hogan) Be very careful with CDC's brand management; beware of diluting it "by becoming another arm of the tobacco control or anti-weight campaign." Focus on the science, the DNA aspects, genomics, etc., to keep reinforcing the brand; do not lose the core of what CDC has been known for over the years.
- (Dr. Lumpkin) There are no interest groups for infectious disease, but their interests counter to chronic disease prevention (e.g., the tobacco industry). Partner with industry on the messages (e.g., food industry regarding obesity), and partner with HRSA to strengthen the healthcare workforce. However, HRSA's own funding to ensure a pipeline for healthcare delivery is always at hazard. CDC is focusing now on strengthening the present public health workforce and developing one for the future, as urged by the Institute of Medicine.
- (Dr. Kelter) A "rising tide could raise all boats, but ... not prevent sinking boats from sinking." Some community health partners are concerned that a governor could rely on CDC and eliminate their state health department (some health departments think they already are). When the median term of a public health officer is 23 months, one has to wonder, he said. The boats have to be intact.
- (Dr. Levin) Many in government appreciate the importance of prevention, but it will be difficult for CDC to be 'the leader' without recognition from the top. A centralization of efforts (e.g., by the DHHS Office of Health Promotion, the Agency for Healthcare Research and Quality (AHRQ) and its U.S. Preventive Services Task Force (USPSTF); HRSA, etc.) is to be hoped for, but not to the detriment of local health departments.
- (Mr. Smith) There must be no diminution of CDC's role in control of ever-present disease, so important nationally and globally. Protect CDC's budget and support. Dr. Gerberding reported some discussion of how much impact CDC can have by "doing things miles wide and inches deep." If the value of investment in CDC can be proven, the investment could rise; that makes results important. When she can assure the Secretary that CDC is as cost efficient as possible with present resources, then she can look for more funding to research other high-priority areas "blessed" by DHHS.
- (Mr. Smith) There have been some increases in syphilis, rather than its elimination, and HIV rates are level or slightly increased. Dr. Gerberding cited CDC's model of

eliminating syphilis county by county. Those with syphilis also have HPV, HIV, etc., suggesting that a strategy to promote sexual health would embrace all of those – something in line with CDC’s new macro approach. Everyone is a “customer,” only requiring different resources and approaches.

- (Dr. Yancey) Who the messenger should be changes with the message; CDC may not be the front person. In obesity prevention, CDC should not be seen as the “food police,” but it has leverage. That type of application (e.g., tobacco control and mandated smoke-free workplaces) has not yet been well explored.
- (Dr. Benjamin) The silence and low profile of local public health is very troubling; data indicate that almost 80% of the public thinks it is unaffected by public health’s work. But linkages made to food and water safety, for example, bring greater understanding. The ageing of the population and chronic disease poses an “unfathomable” economic burden. CDC must use its brand and leverage to build a very effective public health system with many partners. The business community is a major part of that, as evidenced by the success of the tobacco-free workplace. Avoid unnecessary fights, build the infrastructure.
- (Dr. Anderson) Global disease proves the irrelevance of a silo approach and the importance of environmental health. The anthrax mortalities were mostly among workers. Environmental and occupational health are important concepts to emphasize, and linking the two as possible (e.g., as done with the occupational component of the NCEH asthma initiative) in the funding stream is worthwhile. On the other hand, TB control programs have paid little attention to the occupational side, either in funding or state-level integration, other than respirators/hospital safety. Smaller components of these complex issues need to be recognized and built into programs, putting the full weight of public health community behind their solutions.
- (Dr. Mahkorn) CDC plays an important role in prevention, but it should avoid duplication of work with other agencies, such as surveillance.
- (Dr. Frieden) CDC’s brand is about defining the leading causes of mortality/morbidity and rigorously applying epidemiology to identify the most significant problems, proven interventions, and then implementing and monitoring those. Since 66% of death is now from noncommunicable disease, rigorous documentation of what works is needed. CDC should stick to its core values of scientific excellence and advance the epidemiology to support its brand. Dr. Gerberding responded that this defines the “marketing of epidemiology,” developing a science-based intervention and then figure out how to implement it.

Workgroups/Reports

Under the direction of Ms. Cathy Cahill, CDC’s Senior Advisor for Strategy and Innovation, the members formed four workgroups. Subsequently, they reconvened and reported on their discussions of the following topics and questions:

1. Health Goals: CDC wants to increase its impact on people’s health – which would be reflected in the development of impact goals that are bold and focus on health improvement. What goals or concepts for goals would you suggest for CDC?
2. Public Health System: How can CDC help to revitalize the traditional public health system to operate within the larger Health Protection System?

3. Health Protection Research: How can CDC best position itself to address the knowledge gaps in public health in developing an effective Health Protection Research Program?
4. Health Marketing: How can CDC be more effective at marketing health? Please give examples of marketing functions CDC should consider, (e.g., health promotion, policy development, new partnerships with business and health care delivery systems).

Health Goals Workgroup

Reporter: Dr. Yancey

The workgroup discussed obesity and weight management as part of the overarching goals of a life stages system. Also discussed was the need for an accurate and systematic measurement of disease burden and of quality of life through the life stages. Several methods of accomplishing these were framed:

- Create the conditions in which people make healthy choices. Modify the sociocultural and physical environment so that healthier choices are easier to make than unhealthy ones, with attention to cultural diversity.
- Keep food safe and healthy. Issue messages to encourage personal ownership of health decisions as well as to promote them as relevant and actionable long-term, especially for teenagers.
- Support and sustain health community environments.
- Eliminate health disparities and ensure the diversity of the public health workforce, to reflect that of the nation. Value and embrace cultural and sociodemographic diversity.
- Reduce vulnerability to and the burden from disease, injury and disability across the life span. Increase access to a system that incorporates health promotion and disease prevention services. "Health services" means not just health care services, but health services across the board, in which every community has access to the government public health services (a system that needs attention).
- Ensure that children arrive at school healthy and ready to learn, free from domestic violence and environmental hazards in a safe environment.
- Keep Americans safe and healthy at home and abroad; that is, on vacation. That perspective could promote the concept of global health, since disease anywhere in world can come here.

Discussion included the need to delineate between CDC's role and that of government or society in general (e.g., to address a disrupted home life). CDC plays relevant roles in promoting children's health, such as by preventing vaccine preventable diseases, or supporting the creation/reclamation of healthy communities through attention to the impact of the built environment on exercise. But the psychosocial factors that contribute to an ill society require the application of much vaster resources. Figuring out CDC's role and who the other pertinent partners are is the next step.

Health Systems Workgroup

Reporter: Dr. Benjamin

This workgroup addressed workforce training , laboratories, tools, and funding reforms.

Workforce: There is a strong CDC role in building the public health workforce. From a workforce perspective, enough people must be interested and trained to revitalize traditional public health systems at the federal, state, and local levels. Less than 20% of the current public health leadership has formal training in population-based research, as does <40% of the public health workforce overall. Added to that, new skills are needed, such as in informatics, cost analysis and evaluation. This is true universally, but in public health, CDC plays a big role in setting standards and helping to leverage efforts, perhaps in dollars (e.g., bioterrorism funds).

Laboratories. There was a strong sentiment that lab capacity must be rebuilt, especially at the state/local level. Ideally, that construction should be as robust as seen at CDC.

Tools. One area discussed was CDC's power to set standards for making policies or issuing statements, such as consensus statements of best practices. These are very powerful and are used locally to affect funding applications for programs addressing tobacco, sexual practice, etc.

Funding reform. Consensus is needed on what is meant by "public health," what it should look like, and then to adequately fund it. The latter should be totally honest and not try just to do more with less; if the money is not there, do not do it. The field must begin to engage the political leadership: governors, legislators, etc., so that they understand what public health is and how destructive some funding patterns are. Public health needs to be transformed from its current status as, essentially, a poverty program, to a program for whole communities. That includes economic development, rebuilding communities, etc.

Discussion included the observation that no "need" is required to be created; it exists in rising healthcare costs to business. At GE, medical expenses have risen over a billion dollars. Business needs a solution, not seen to date, to define how public health is the "x" factor that could address increased healthcare expense. Daimler-Chrysler and Benz pay more on healthcare than they do on the steel in their cars. They spend \$400 million a year to cover 1.2 million lives, which includes 90,000 diabetics. They developed a model that can almost predict who will develop diabetes. Dr. Bender felt that the ability to address these problems is already present and will grow through partnerships between the public and private sectors. And that feeling, expressed by business, has more impact than when it comes from public health.

The extent to which the currently-known best practices are used was raised. For example, 30% of physicians do not check blood pressure. Such structural work as education of practitioners on the practices that smooth the running of a practice (e.g., the cost effectiveness of electronic records, immunization registries, etc.) is needed. "Practitioners" include those who actually make the office run: the nurses, nurse practitioners, etc., to ensure that nothing needing to be done slips through the cracks.

The problem is that these are just the kind of programs that will suffer the cuts now anticipated. Some areas may be addressable by the AHRQ and DHHS is addressing some as well. The case for government, however, differs from that for business. For the latter, return on investment is predominant; for government, the issue is politics. Having at the table the business partners who were already won by the ROI case provides optimal support. But the interest of HMOs and insurers in prevention needs to be stimulated, and could be, with cost effectiveness analyses. The trip to Africa with the Secretary illustrated how much can be done with little funding, if the political leadership supports the work. CDC was urged to speak out so.

Health Protection/Research Workgroup

Reporter: Dr. Billingsly

This workgroup discussed what research is needed and how to apply it when that is known.

- In the area of immunization, research is needed to determine why people do not get immunized, how to improve immunization rates, and how to advertise their importance.
- In the marketplace, CDC has a complementary role to the FDA in validating new health-related products (e.g. vaccines, or prioritizing new products for the market).
- Research on psychosocial factors is needed, those which motivate people to do or not do something such as changing behavior. For example, the data indicate that motivating people to change affects the patterns of obesity (e.g., by eating together as a family at least three times a week). The data indicate that as helpful to affect obesity and to lower the rates of juvenile delinquency and teenage pregnancy.
- The strengths for which CDC is known, such as infectious disease and bioscience, must not be neglected in the course of picking up new activities.
- Interest and money hinder or support the application of present knowledge. CDC's excellent brand supports the applied and translational research that shows how to apply knowledge, and partnering with other agencies avoids duplication and advances the field further.
- Just as in medicine, the evidence base is lacking. The sanitation research that began public health as a field is at least 50 years old. A new science base is needed to prove the principles that have been accepted, in some cases, for eons (e.g., to not run a water pipe under the sewer line) and to evaluate new technology (e.g., applied research on using radiation to detect leaks in water pipes).

Health Marketing Workgroup

Presenter: Mr. Hogan

This workgroup discussed how to market CDC, protect its brand, and disseminate its information. The first conclusion was the need for CDC to understand its culture, values, and present brand. Extending the latter is OK, but it must not be diluted. Rigorous, science-based information is critical, and the brand must be safeguarded. If needed, professional help to ensure the internal understanding of those things should be obtained.

- Marketing needs to be defined within the organization; clinicians think it is lying, and there are very different definitions even in business. Everyone in the organization needs to agree on what the marketing means.
- Safeguarding the brand: Do not go after obesity, for example, unless there is a great scientific basis to do so. The research need not be CDC's original research; it could be others' clinical or research data of such excellence that it is worthy of CDC's brand.
- As much as possible, personalize the message for maximum impact. For example, GE's new CT scan can noninvasively measure blood vessel plaque within 30 seconds. Seeing that picture with the clinical data changes the patient's lifestyle dramatically. Use of the life stage approach should similarly help.
- In disseminating information, CDC should be selective to contribute where it can add value. Channels such as professional organizations, etc., should be identified to leverage CDC's own credibility in conveying the message, along with its natural channels of hospitals, clinicians, and researchers.
- Marketing CDC as an expert in public health, as well as an expert in infectious disease, will help to advance public health as a whole through brand transference. The messages delivered should be clearly based on the science (e.g., "we tested cigarette smoke and this is in it and it is bad for you," as opposed to "don't smoke, it's bad for you.")

Ms. Cahill thanked the committee for its good ideas, which also provided confirmation of CDC's current direction. Dr. Gerberding reported CDC's work with the APHA leadership on the questions relevant to the public health system. The committee's input will help to focus on what can be done. CDC will do the research to develop the knowledge of how to successfully implement, not implement it itself; and extramural research can build on that. She reassured the members that CDC has very rigorous criteria that protects its brand, involving extensive levels of review.

Public Comment was solicited, to no response.

An update was provided on the **VERB Campaign** by NCCDPHP Director Dr. Jim Marks. To counter the more rapid acceleration of obesity among children than adults, the VERB campaign was designed to increase and maintain children's activity levels by presenting physical activity as cool and fun. The message is that kids can be active on their own and do not need an organized sport. "VERB, it's what you do" became the brand around which paid media, Website links, community events, etc., were built. It was developed by Madison Avenue's best at reaching children (e.g., advertisers for Pepsi/Coke, McDonald's, etc.). Industry interest was so high that CDC had to limit the companies allowed to pitch. The winners provide an additional \$75 million of wide variety of in-kind support to the \$150 million budget (about the cost of a Taco Bell campaign; the tobacco industry spends \$11 billion/year). The talent on contract was often donated. Some marketing companies worked to target Hispanic-Americans, Native Americans, Asians, and African-Americans.

A baseline telephone survey done in spring 2002, before the campaign began in late spring/early summer, was compared to data collected a year later from a national sample and six high-dose

communities. The campaign target, that 50% of children would be aware of it, was passed very early on. A year later, the brand recognition was 74% and 85% in high-dose communities, and 34% and 53%, respectively, among the parents.

Specific data were presented that reflected a stunning success among children aged 9-10 years old (engaged in 75% more physical activity sessions), among boys slightly more than girls, and a positive effects among sedentary children (in which group girls bested the boys). A positive effect was even shown among some parents (34% overall and 53% in high-awareness groups). The pattern of positive effects directly attributable to VERB were found in four important groups surprisingly early in the campaign: younger children aged 9-10 years, girls aged 9-13 years, teens in households with annual incomes <\$25,000 and those between \$25,000-50,000. The VERB Website is getting a million hits a month.

The companies involved had never seen such an effect in one year for any snack food or other campaign. They were surprised to see that behavior change could be accomplished in one year. These are the first data to prove that children's behavior can be positively influenced regarding physical activity. Dr. Marks acknowledged that this campaign would not have been as effective if it were done in house. CDC was fortunate to get the expertise provided.

Discussion noted the spillover benefits among some parents and the need to sell this program on the Hill, as its funding has dropped dramatically.¹ Dr. Gerberding stated that no new funding will be requested. Dr. Marks hoped that the impending release of the data would let the campaign speak for itself, proving in principle that this kind of campaign can produce the desired result. But as companies know, the momentum of a successful campaign must be maintained; that decision about VERB is now up to the society.

An **Overview of CDC's Media Methods** was provided by Dr. Marsha Vanderford, Director of the Office of Communication. CDC communication go well beyond media, including health communication, media relations, provision of information under the Freedom of Information Act, maintenance of the Global Health Odyssey display and information center, etc.

The breadth and depth of the communication challenges change rapidly especially in emergency response. The pathways used to facilitate that flow were outlined. To meeting the critical need to segment audiences (e.g., through Epi-X, HAN), information can be sent based on security level needs, from highly secure to broad public dissemination. Demographic variables were charted, compiled with the associated schools of public health and 55 focus groups, to determine if the knowledge base of the segments made a difference in the content and channels of delivery for certain groups. CDC's communication experiences were outlined with Hurricane Isabel, in 2002 and with the 2004 ricin exposure in Washington, D.C. In the latter case, the ricin Web page was updated within hours and a notice was issued on the HAN system. Within 12 hours, there were 65,000 hits on the Web page from 12:01 a.m to 1:45 p.m.

¹ \$125 million to launch in FY01; \$68.4 million on FY02; \$51.3 million in FY03, and projected \$36 million in FY04.

An Update on Avian Influenza was presented by Dr. Nancy Cox, Chief of NCID's Influenza Branch. She outlined the outbreak of influenza A (H5N1) in Asia. Birds, particularly aquatic birds, are reservoirs of disease and can transmit it to domestic poultry. The viruses mutate to grow in domestic poultry and, when in contact with humans, sometimes mutate to infect human-to-human. A review of the influenza experience of the last 6-7 years was provided. This year, there have already been 202 cases of HA H5N1 avian viruses and 20 confirmed deaths. All reported human cases have been in Vietnam and Thailand, but the circulation of these avian viruses is massive in Asia. The virologic/epidemiologic criteria for a pandemic require a novel HA subtype and naive populations, one that causes morbidity and mortality in humans (all fulfilled) and is easily transmissible from person to person (possibly fulfilled).

CDC is developing tests with the WHO to update their kit to identify H5N1 viruses for distribution to all WHO global influenza program labs. As H5N1 is isolated and identified, a rapid detection method can be developed for H5 using real-time PCR analysis as samples arrive. Work is also being done on a "conventional" H5N1 vaccine with modified highly-pathogenic avian virus, using plasmid-based reverse genetics.

In summary, poultry outbreaks caused by HPAI H5N1 viruses were reported in Cambodia, China, Hong Kong (SARPRC), Indonesia, Japan; Laos, S. Korea, Thailand and Vietnam. Highly pathogenic human cases were reported by Vietnam (15) and Thailand (5), and 16 deaths. No human cases reported elsewhere, but based on previous experience and what is known about the virus itself, CDC and WHO think that there must be other human cases. In one family cluster in Vietnam, the WHO could not rule out human-human transmission, but most of the cases had exposure to sick or dead birds.

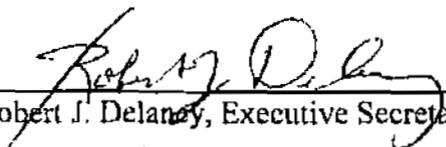
The H5N1 viruses isolated have been heterogeneous antigenically and genetically, which would challenge vaccine development. Candidate vaccines from the 2002-03 H5N1 strain are not a good match. Vaccine development is vigorous at two labs in the U.S., including at CDC. The human isolates from Vietnam and most avian isolates are resistant to adamantanes; only neuroaminidase inhibitors would work to address this virus. There is a real need for genetic/antigenic samples from countries beyond Vietnam and Thailand. Reassortment is possible from a mutation, if the two viruses circulate and combine in a human exposed to both. There is poor or no human influenza surveillance in several of the countries with affected poultry outbreaks (e.g., Laos and Cambodia). Reported pig die-offs in southern Vietnam are being studied. Swine are thought to be an intermediate host, susceptible to both avian and human flu viruses. These could mutate in them as well, to be more adaptable to mutation in animals. Culling is being done to reduce the risk of human infection, but human exposure continues in developing countries where backyard flocks constitute the majority of poultry.

Dr. Gerberding summarized that this is why CDC is taking this outbreak so seriously. This pathogenic threat has never been seen before, but there is reason for hope in the world's greater ability to track and assess risk. CDC will continue to work with the WHO on this. Finally, she thanked the members for their attendance and input, Ms. Cahill who leads the CDC Futures Initiative, the presenters, and all those who helped to make the meeting a success. She welcomed

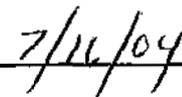
all comments to her directly through e-mail or through Ms. Cahill or Mr. Delaney.

With no further comment, the meeting adjourned at 3:33 p.m.

I hereby confirm that these minutes are accurate to the best of my knowledge.



Robert J. Delaney, Executive Secretary



Date

ATTACHMENTS

ATTACHMENT #1: ATTENDANCE

Committee members present:

Joel Reed Bender, MD, PhD, MSPH, Corporate Medical Director, General Motors Corporation, Detroit, MI

Georges Benjamin, MD, FACP, Executive Director, American Public Health Association (APHA)

Marilyn M. Billingsly, M.D., Associate Professor of Internal Medicine, St. Louis University, St. Louis, MO.

Mary desVignes-Kendrick, MD, MPH, FAACP, Director, City of Houston Department of Health and Human Services

Thomas R. Frieden, M.D., M.P.H., Commissioner, New York City Department of Health and Mental Hygiene.

Robert L. Galli, M.D., Professor and Chair, Emergency Medicine, University of Mississippi Medical Center, Jackson, MS.

Joseph M. Hogan, President/CEO, General Electric Medical Systems, Waukesha, WI.

Debra Lappin, J.D., Director's Council of Public Representatives, National Institutes of Health

Alexander R. Lerner, Executive Vice President/CEO, Illinois State Medical Society, Chicago, IL

Sandra K. Mahkorn, M.D., M.P.H., M.S., Chief Medical Office for Health Information, Division of Health Care Financing, Department of Health and Family Services, Madison, WI.

Joe S. McIlhaney, M.D., M.P.H., M.S., Founder/President, Medical Institute for Sexual Health, Austin, TX.

Shepherd Smith, Founder/President, Institute for Youth Development, Sterling, VA.

Antronette K. Yancey, MD, MPH, FACPM, Adjunct Associate Professor, University of Southern California School of Public Health

Chairs of CDC Advisory Committees present:

Dr. Henry A. Anderson, Advisory Committee to the National Institute for Occupational Safety and Health (NIOSH)

Dr. Enriqueta Bond, Advisory Committee to the National Center for Infectious Disease (NCID)

Dr. Glen Caldwell, to the Hanford Health Effects Subcommittee (HHES)

Dr. Kowetha A. Davison, to the Oak Ridge Health Effects Subcommittee (ORHES)

Dr. Robert E. Fullilove, CDC Advisory Committee on HIV and STD Prevention and Treatment

Dr. Mary Greenberg, Executive Secretary, National Committee on Vital and Health Statistics (NCVHS), NCHS

Dr. Alex Kelter, Advisory Committee to the National Center for Injury Control and Prevention (NCIPC)

Dr. Myron Levin, Advisory Committee on Immunization Practices (ACIP)

Dr. John Lumpkin, Advisory Committee to the National Center for Health Statistics (NCHS)

Dr. Masae Kawamura, Advisory Council for the Elimination of Tuberculosis

Dr. Melissa McDermott, Board of Scientific Counselors to the Agency for Toxic Substances and Disease Registry (ATSDR)

Dr. Patricia A. Nolan, Advisory Committee to the National Center for Environmental Health (NCEH)

Dr. David Sundwal, Clinical Laboratory Advisory Committee (CLIAC)
Dr. Robert A Weinstein, Hospital Infections Control and Prevention Advisory Committee
(HICPAC)
Dr. Fran Wheeler, Advisory Committee to the National Breast and Cervical Cancer Early
Detection Program

DHHS staff present: Costas Miskes, DHHS administrator for the Southeastern region; Marco
Villagrana, Ann O'Connor, Minan Zadel.

CDC staff present:

Sue Binder	Richard Jackson	Tom Sinks
Stephen Blount	Muin Khoury	Suzanne Smith
Steve Boedigheimer	Beverly King	Dixie Snider
Claire Broome	Paula Kocher	Steven Solomon
Susan Chu	Helen Kuykendall	Amanda Tarkington
John Cisco	James Marks	Stephen Thacker
Steve Cochi	Verla Neslund	John Tibbs
Nancy Cox	Steve Ostroff	Marsha Vanderford
Henry Falk	Michelle Pearson	Walter W. Williams
William Gimson	Tanja Popovic	
Robin Ikeda		

Members of the public:

Marie Murray, Recorder
Thomas Zink, GlaxoSmithKline Vaccines
Katherine Lyon Daniel

Attachment #2: ACD "Sound Bite" Suggestions

Public Health is....

- The people who help whole communities improve their health.
- Talking care of people/communities.
- People, technology, and know-how for a quick action to keep you safe.
- Protection of the health of all people through detection of threats and communication of the threat and means of protection.
- Sum of all activities, public and private, aimed at protecting and advancing the well-being of US residents.
- Protecting and enhancing health and well-being of people in a changing environment.
- Bringing science forward to improve lives.
- Promoting health and preventing disease for communities as well as individuals.
- Complete health protection: families to communities; local to global.
- Makes you better; shows you how to stay well; wellness, disease prevention, and health protection.
- All the infrastructure, people, and information that go into promoting health and preventing disease...clean water and air...control infectious diseases...improve and maintain health.
- Helping you help yourself to live a healthier, happier, and longer life.
- Creating a culture that puts the health of all as the top priority.
- Coordinated systems to protect the health of the community.
- Public Healthcare support and infrastructure targeted to promote and enhance individual commitment to maintaining one's health.
- Enhancing quality of life.
- Safer, better, longer lives for everyone, through prevention.
- Society's organized effort to protect and promote health through monitoring and action.
- Assuring the public that they are protected to the greatest extent possible from any and all health-compromising conditions that would adversely affect their morbidity and mortality.

Attachment #3: FY04/05 CDC Budget

FY 2004 budget, signed January 23, 2004:

Total Funding: \$7.1 billion (\$132 million over FY 2003):

- CDC non-terrorism programs: \$5.9 billion
- CDC terrorism programs: \$1.1 billion
- ATSDR: \$73 million

Major increases were allocated to:

- Global Disease Detection: +\$15 million – funds pandemic influenza preparedness and response, malaria prevention and control, training and technical assistance both for CDC staff and for health care workers in foreign nations, international partnerships to prevent and control disease outbreaks, surveillance enhancements internationally, and disease prevention activities
- Public Health Research: +\$15 million – funds CDC's peer-reviewed research, to expand internal research activities and to encourage applied research among extramural partners.
- Public Health Information Network: \$10 million total funding allows CDC to create a network of public health information systems that include the Health Alert Network (HAN), the National Electronic Disease Surveillance System (NEDSS), and the Epidemic Information Exchange (EpiX), among others. These allow for nationwide connectivity and real-time information sharing in public health emergencies such as terrorist attack or disease outbreak, or other public health emergency.
- STEPS to a Healthier U.S. Program: +\$28 million – funds work to prevent diabetes, obesity, and asthma in several states, tribes, and cities nationwide. This funding will support community-based programs that are proven to control these three diseases and their related risk factors – physical inactivity, poor nutrition, and tobacco use. An additional 4 communities will be funded in FY 2004, for a total of 27. Total funding for FY 2004 is \$44 million.
- Global Mother-to-Child HIV Prevention: intended to be funded at \$109 million to expand work in the Global AIDS Program countries, was transferred to the State Department.
- Autism: +\$5 million – funds the expansion of existing programs in autism research and monitoring.
- Nutrition, Physical Activity, and Obesity: +\$11 million – increases funding for these programs to \$45 million.
- Cancer prevention and control: +\$25 million funds the following – Geraldine Ferraro Cancer Education Program, +\$5 million; Breast and Cervical cancer, +\$10 million (total of \$314 million); cancer registries, +\$4 million; colorectal cancer, +\$1.5 million; comprehensive cancer, +\$2.6 million; ovarian cancer, +\$0.5 million; skin cancer, +\$0.5 million; prostate cancer +\$1.5 million.

FY 2005 Budget Request to Congress (submitted February 2, 2004)

Total CDC Funding: \$6.9 billion:

- CDC non-terrorism programs: \$5.7 billion

- DC terrorism programs: \$1.1 billion
- ATSDR: \$76 million

This constitutes major increases to the following programs:

- STEPS to a Healthier U.S.: +\$81 million – funds 63 communities.
- Biosurveillance: +\$130 million – funds include \$100 million for BioSense, \$20 million for laboratory surveillance, and \$10 million for border health and quarantine stations. The Biosurveillance initiative will be funded from a redirection from the Bioterrorism Cooperative Agreement (\$105 million), upgrading CDC capacity (\$15 million), and anthrax research program, which is ending in FY 2005 (\$10 million).
- Breast and Cervical Cancer: +\$10 million – funds 32,000 additional screenings and Project WISEWOMAN for up to 14 states.
- Health Statistics: +\$22 million – funds expansion of four major surveys: Vital Statistics, NHIS, NHANES, and Healthcare Delivery Systems.
- Global Disease Detection: +\$28 million – funds work on emerging infections, the Field Epidemiology Training Program, early warning systems and improved communication.
- West Nile virus: +\$2 million – funds increased surveillance and response activities.
- ATSDR: +\$3 million – funds investigation of 5 of 28 listed vermiculite processing sites and increases funding for the maintenance of the World Trade Center Registry.
- Immunization: +\$56 million – funds the Vaccines for Children (VFC) program, the discretionary 317 program to states, and global funding. Another 5500 sites will be added to the VFC to provide access points for under-insured children, to provide Td/DT vaccine for an estimated 3.4 million children. This funding also provides a stockpile of influenza vaccine (\$40 million, also included in FY 2004).

This budget decreases funds for the following programs:

- VERB: -\$31 million (to total \$5 million) – this will only allow one targeted marketing effort (FY 2003 funding was provided to 15 communities.)
- Public Health Improvement: -\$59 million – This covers two decreases: one of \$44 million for one-time congressional earmarks from FY 2004, and one of \$16 million for the elimination of 26 extramural prevention research projects.
- Buildings and Facilities: -\$179 million – The remaining \$81.5 million will fund continued work on CDC's Ft. Collins, Colorado facility (\$44 million), beginning work on the East Campus Laboratory Consolidated Project (\$9 million), and continued repairs and improvements (\$29 million).