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**Advisory Committee to the Director
Centers for Disease Control and Prevention (CDC)
Emory Conference Center
Atlanta, GA**

**Meeting Summary
August 25, 2005**



**Department of Health and Human Services
Public Health Service**

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Acronyms used in this report

ACD	Advisory Committee to the Director of CDC
ACIP	Advisory Committee on Immunization Practices
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officers
BSC	Board of Scientific Counselors
CBER	Center for Biologics Evaluation and Research (FDA)
CDC	Centers for Disease Control and Prevention
C/I/O	Centers, Institutes, and Offices
CMS	Centers for Medicare and Medicaid Services
CCID	Coordinating Center for Infectious Disease
CCHIS	Coordinating Center for Health Information and Services
CCEHIP	Coordinating Center for Environmental Health and Injury Prevention
COPTER	Coordinating Office for Terrorism Preparedness and Emergency Response
COGH	Coordinating Office for Global Health
DFO	Designated Federal Official
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DOD	Department of Defense
FTE	Full Time Employee
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
IRB	Institutional Review Board
NCHSTP	National Center for HIV, STD and TB Prevention
NIH	National Institutes of Health
NACCHO	National Association of County and City Health Officers
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NICHD	National Institute of Child Health and Human Development
NIOSH	National Institute for Occupational Safety and Health
OMB	Office of Management and the Budget
RCT	Randomized Controlled Trial
SNS	Strategic National Stockpile
VFC	Vaccine for Children (Program)
VRBPAC	Virology and Related Biological Products Advisory Committee

**Centers for Disease Control and Prevention
Advisory Committee to the Director**

Summary Minutes of the August 25, 2005 Meeting

A meeting of the Advisory Committee to the Director (ACD) of the Centers for Disease Control and Prevention (CDC) was held on August 25, 2005, in Atlanta, Georgia. The meeting was convened at 8:12 a.m. by Executive Secretary, Mr. Robert Delaney. Chairperson, Dr. John O. Agwunobi welcomed the members and other attendees, listed on Attachment #1.

AGENDA

Welcome/Introductions

Dr. Agwunobi reported Mr. Smith's request for in-depth discussion of CDC's work on HIV/AIDS. In view of the meeting's time constraints, Mr. Smith agreed to Dr. Agwunobi's suggestion that a formal workgroup be formed to discuss that and related strategies, to report back to the full committee for discussion. Nods around the table indicated consensus to the proposal.

State of the CDC

Dr. Julie Gerberding provided an update on the state of the CDC, beginning with staffing at the CDC center and office levels. After input in 2003, CDC's restructure began in April 2004. The staff is settling into the new structure. New staff hires include senior management officials to work with each of the six Coordinating Centers' Directors, and another in the Career Development Office. Nine hundred indirectly funded FTE's were reassigned to directly funded services.

Details were provided on goals related to CDC's three strategic imperatives:

1. Achieving the greatest health impact possible through a holistic, life-span approach carried out through categorical specialties. Representative programs outlined ranged from "Start Strong" (infants/toddlers) to "Live Better, Longer" (ages ≥ 65 years).
2. Healthy people in healthy places, where they live, work, learn, and play, will protect and promote their health and safety. Representative programs were outlined in these settings, including travel and recreation.
3. Global health: healthy people in a healthy world, through health promotion, health protection, and health diplomacy. Under the Homeland Security/Patriot Act, CDC is assigned 28 preparedness goals. Its focus is on six: pandemic influenza, anthrax, plague, emerging infections, and exposure to toxic chemicals and radiation.

The Committee's advice over the next few weeks was requested on CDC's development of 21 goal action plans, which will cover the work of about 70% of its Centers. These plans will address the life stages (5), healthy places (7), global health (3), and preparedness (6 in the first round). The "Start Strong" program was outlined as an example.

The action plan process will build on the lessons learned from the Goal Trailblazer projects: the need for a science basis, for external expert contribution, and for comprehensiveness and consistency across the agency. One action plan will address adolescent health through the CCEHIP. It will coordinate work across 18 different Divisions to address injury prevention, the most preventable health impact and strongly linked to adolescent risk taking behavior. After consultations with internal and external experts, the public and advisory committees, a scientifically rigorous action plan will be developed. The measurement of key performance indicators will show the result on adolescent health over time.

The Goal Teams will be created this fall and a new system, healthimpact.net, will help to track their accomplishments. They will inventory current activities, align the action plans with present (or create new) CDC objectives, and assess unmet needs. The plans will be reviewed in senior management retreats, by the advisory committees, at the CDC Partners Meeting and in public forums. The plans will contribute to budget proposals and will be executed and realigned over the next 3-5 years according to their assessed impact. Success will help prove that health protection is a high priority worthy of funding.

Discussion included:

- Surgeon General Richard Carmona is very interested in this process, especially regarding the aspects of chronic disease and the coordination of work across DHHS. Dr. Agwunobi has been nominated as Assistant Secretary of Health.
- Dr. Beasley urged the Goals alignment with realism as well as science in order to avoid discouraging results. To advance the necessary team building, he stressed Dr. Gerberding's ability as the leader to "make people talk, which gets them to start thinking."
- Interagency coordination is already fostered through mutual staff placement by CDC and the Departments of Education, Agriculture, Defense, FDA, as well as the creation of a "virtual center" with CMS. Dr. Bender liked that as a way of identifying pockets of expertise, but cautioned that team building must be real and proven by performance.
- Dr. Agwunobi advised attention to the transition points between the life stages (e.g., early infancy, older children); to avoid frequent service gaps that especially affect poorer children.
- Emerging Infectious Disease Goals will be addressed through scenarios rather than particular diseases.
- Dr. Frieden asked that the January-March review phase include sharing the goal action plans for Advisory Committee comment.
- Dr. Agwunobi suggested development of a life stages map based on science for communities as well as individuals. Dr. McIlhaney further suggested

development of a very succinct life plan or “vision” for Americans (i.e., “follow this plan of activity and you’ll be healthier on the day you die.”)

- There is a frequent disconnect between what people want and think they need. It is not government’s role to tell people how to live, but CDC can build and advertise the evidence base to support healthy decisions.

CDC Morale. Dr. Gerberding addressed concerns about workforce morale, which can be expected to be affected by reorganization. CDC employees’ job satisfaction was surveyed at probably its lowest point, as the reorganization was implemented. However, some morale boosting and lowered attrition is hoped from promotions within the Public Health Commissioned Corps. Lessons on achieving greater organizational diversity at CDC also are being pursued through consultations with the National Academy of Public Administrators (NAPA), NASA, GE, and other organizations. Further reports on CDC staff and morale will be provided at the next meeting.

Discussion included:

- Reservations about CDC’s reorganization have been expressed. The public health community and key stakeholders need reassurance that their coordinated work with CDC will continue.
- Broader input on the reorganization will be sought from CDC’s ~500 partners, beginning with a September 18 meeting with their leaders to discuss coordination. (For example, one CDC staffer will oversee and coordinate the 15 different AMA projects throughout the agency.)

Dr. Agwunobi had to leave, as Hurricane Katrina was bearing down on Florida. Before leaving, he applauded the work of CDC’s building program, done “on budget and on time,” to create an impressive campus. Dr. Galli assumed the Chair in his place.

Presentations

MedKits

Dr. Michael Bell, of NCID’s Division of Viral and Rickettsial Diseases, described the development of concepts and testing strategies for pre-deployed home supplies of countermeasure drugs (MedKits). Drugs envisioned as part of the MedKit include antimicrobials and countermeasures for exposure to radioactive material. MedKits were conceived as an adjunct to other planned or existing countermeasure delivery methods, including traditional dispensing points, direct postal service delivery to homes, community-based emergency caches and inclusion in first responders’ equipment.

Potential benefits of MedKits include rapid availability of preventive therapy, avoidance of waiting in lines for dispensing, and prevention of excessive burden on the local public health systems during a crisis. The countermeasures would be available as oral preparations, FDA-approved for prophylactic use, and have an acceptable safety profile with minimal risk of toxicity. These might include doxycycline (antibiotic), potassium iodide and Prussian blue (for radiation exposure), and perhaps Tamiflu (influenza).

Potential challenges include the pharmaceuticals' limited availability and the need to balance needs for stockpiling and MedKit dispensing against normal use, especially for antimicrobial drugs; adverse outcomes from incorrect use; and infrastructure and support requirements (adverse event tracking, expiration and resupply needs, disposal requirements [e.g., to avoid environmental contamination by degradation products from discarded medications, or unwittingly spreading antimicrobials into the environment]; and establishment of notification systems for their use). Other issues include the need to address questions regarding insurance payor responsibilities, prescribers' liability, equity of distribution (in discussion with HRSA), and prioritization of a potentially limited supply.

A suggested protocol for the evaluation of the MedKit concept has been provided for review by the department. The protocol is for a one-year study to determine acceptability, utility and effectiveness of the delivery method, i.e., do recipients like the MedKit, can they maintain the MedKit according to instructions, and can they find it when needed.

Discussion included:

- Tamiflu stockpiling has already begun in other countries such as China. How Americans living abroad would be handled was unknown.
- The combined use of existing and new systems was appreciated, but the process must be tested – including measurement – before any crisis. Other dispensing sites could be pharmacies; community, STD or corporate clinics; and physicians' offices.
- State decision makers will need to know all the advantages and disadvantages identified by CDC's active comparative evaluation.
- Dr. McIlhaney suggested identifying a corps of local community volunteers to deliver these kits in times of emergency, as done for polio vaccine in India.
- Local health departments will be able to advise on related issues, such as the needs of the elderly, potential issues with different religious groups, and the different needs of regional, urban or rural settings.

Pandemic Influenza

Preparedness for pandemic influenza was addressed by Dr. Richard Schieber, CCID Senior Advisor for Influenza. Preparation for the next influenza pandemic presents an opportunity both to prove the value of and to improve public health response. CDC response involves the coordinated work of CCID, CCHIS (Informatics), COPTER (the SNS home), COGH (FETP program), and NIOSH (N95 respirators).

An update on the spread of A/H5N1 animal avian influenza tracked it through Asia, in part along migratory bird pathways. Of >100 people who contracted the disease, half have died. The WHO planning cycle for pandemics addresses six phases. This avian influenza is now in phase 4, presenting small clusters of human-to-human transmission; sustained transmission initiates phase 6.

Countermeasures underway include the development of H5N1 vaccines in the U.S. and Hanoi. NIH preliminary clinical trial reports dashed hopes that immunogenic needs could be met with a 15 microgram dose; 90 mcg delivered in two doses appears to be necessary, or 600 million doses total for its entire population. The use of an alum adjuvant and intradermal vaccination to stretch the H5N1 vaccine supply when it becomes available is in discussion. More information should be available in the next few months. A contract for the egg supply needed for vaccine production is in place and cell-culture based vaccine development also has begun. H5N1 resistance to the antiviral Amantadine has been documented, but it is still sensitive to Oseltamavir (Tamiflu) and Zanamivir (Relenza). Isolation and quarantine of patients with avian influenza is allowed by the April 2005 Executive Order. An emergency supplemental budget item for FY05 provided \$15 million to CDC to develop better public health surveillance and countermeasures in Southeast Asia, specifically Vietnam, Laos, and Cambodia.

Progress in CDC's role of pandemic readiness was reported.

- All states had a pandemic response plan in place by July 2005 and have contributed to the national plan. Many have done table top or large-scale vaccination exercises. The DHHS Secretary is developing a comprehensive plan to include all agencies relevant to the likely impact of a national pandemic (e.g., the Departments of Commerce, Justice, Education, etc.). The states still face the uncertainty of a vaccine supply (dependant on clinical tests) and antivirals (dependant on Roche production capacity), as well as their own healthcare system's uncertain surge capacity (determined hospital by hospital). They normally have on-site an estimated 1-2 day supply of the medicines and tools needed for response, and up to a week when resupplied by local distributors.

Needs thereafter for a pandemic would be met in part by the SNS. Such delivery is planned to occur within 12 hours, with most deliveries likely to be state health departments. The SNS has ~1 million hospital masks (residual from SARS) and is planning purchases of gowns and gloves. Another 2 million adult doses of Oseltamavir will supplement the 2.3 million doses in stock, with a total of 20 million are planned to be stockpiled.

Quarantine: In 2003, only eight of the original 300 quarantine stations in the U.S. remained. As part of an expansion effort to protect our nation's borders from infectious disease threats, three additional stations were added in 2004, and seven in 2005, bringing the total to 18 stations in the United States. In addition to the new stations, CDC staff capabilities have been expanded to include medical officers, inspectors and public health advisors. In the near term, in order to have representation at the ports of entry that receive 80% of the US international arrivals, an additional seven stations are needed. A recent report from the Institute of Medicine, which reviewed the quarantine expansion process, concluded that the network of CDC quarantine stations should strategically lead the US in its efforts to minimize the risk of microbial threat of public health significance that could enter this country, and to establish and formalize state, local and key public

health partnerships to develop an effective response network that can be executed on both a routine and emergency basis.

Due to time constraints, Dr. Schieber recommended that the committee read the balance of his slides on pandemic preparedness. These addressed CDC's accomplishments and challenges related to communications, epidemiology and surveillance, and the gaps related to the latter.

Discussion included:

- Dr. McIlhaney asked if evidence indicates an imminent pandemic. Dr. Tim Uyeki reported 57 deaths out of 100 cases and reports of a new strain with greater capacity for person-to-person transmission. If that strain genetically mutates to become easily transmissible, the disease will rapidly go worldwide. This is a tremendous threat to highly populated areas. The twentieth century's three global influenza pandemics demonstrated such gene mixing. Influenza's challenge is in its dynamic, continually evolving nature. The vaccines developed with the 1997 Hong Kong outbreak strain are of limited effectiveness to this antigenic strain; and even this year, those isolated in Indonesia differed from those in Vietnam and Cambodia. Continued laboratory surveillance is needed to make a vaccine that addresses the right strain.
- Dr. Ray Strikas explained that the 9-month lead time for egg-based vaccine production is a further challenge. A cell culture vaccine could avoid that step and speed production.
- WHO regulations are being discussed to prevent potentially ill people from leaving a country, versus the current quarantine upon arrival. The IOM issued a recent report on the U.S. current quarantine capacity. Temperature detection was used at airports late in the SARS epidemic, but was not necessarily useful in reducing the threat. It mostly deterred people with fever from going to the airport.
- Drs. Gerberding and Schieber assured Mr. Smith that there definitely was a vaccine crisis last season. He asked how the private sector could provide the huge quantities of vaccines needed in a pandemic. Dr. Schieber reported DHHS' discussion of production boosting incentives for vaccine companies, greater reliance on cell-based production, or some combination of those. Dr. Strikas hoped for U.S. licensure of another vaccine manufacturer, with factories in North America if not the U.S. Influenza vaccine-stretching trials also are underway. Sanofi Pasteur's construction of a plant in Pennsylvania, with Congressional support to remove roadblocks, will help compensate for Chiron's potential absence from the market (unpredictable at the time of this writing), but the production lead time remains long. And, although the NIP can influence the pediatric market with its VFC purchase contracts, it has no such influence for adult vaccines.
- Dr. Frieden defined the most challenging preparedness issues as Tamiflu stockpiling and hospital ventilator stocks. More awareness about Tamiflu, hospital capacity, etc., is needed to address the many unknowns in this high stakes issue. Dr. Beasley noted that subcutaneous vaccination requires different needles

and syringes. Such tools, and workforce training, will all have to be in place, *if* that approach even works.

Dr. Gerberding reported that the stockpile is planned on a 20/20 basis: sufficiently stocked to immunize 20 million people and Tamiflu to treat 20 million more, while production ramps up for the pertinent strain. With Tamiflu being ordered internationally, it is hard to predict the stock, but the SNS is continuing to stockpile up to the initial target of 20 million.

Portfolio Management Project

Project Director, Mr. Michael Sage outlined the Portfolio Management Project. Its goals are to network CDC and state/local health departments, aligning the investments to health goals and managing/leveraging them to health impact, as well as improving business services and coordinating/managing CDC field staff.

The grant-funded research portfolios of the states vary widely. For example, of Ohio's \$130 million for 41 grants, most goes to the state health department, while much of New York's ~\$500 million of 80 grants goes to community based organizations, academic institutions, etc.

From January to June of this year, seven of eight portfolio managers were recruited and placed (Ohio, New York, Texas, Washington, Arkansas, D.C., Florida; California is pending). Two-year project plans were approved and initial portfolio assessments were done. CDC's support structure is developed and the leadership network development was begun. ASTHO is collaborating on the evaluation.

Selected early observations of coordinating center grant programs included:

- Categorical programs have become more restrictive and narrowly focused. CDC is examining why that happened and whether they can be refocused.
- Inconsistent grants management policies across programs are being reassessed.
- No information management system currently can provide an analytic capability for strategic decision making.
- Significant resources, although not as high as those to state/local health departments, are going to NGOs without strategic analysis or performance management approaches. That is being examined. In some cases in New York, community based organizations also were funded by state/local health departments, sometimes using the same statement of work.

Future planning issues of sustainability, transferability and expansion were outlined.

Discussion included:

- One aspect of this project is to analyze whether infectious disease is the right focus and what the measurable outcomes should be.
- The Clinton Administration put formerly-exempt CDC field staff under the FTE ceiling, which reduced their total from 2200 to 480. Dr. Frieden lamented this

crucially important policy decision, attributing the lack of that cadre to cities' and states' major problems in preparedness. Dr. Gerberding responded that preparedness activities are exempt from the ceiling, but not others. Congress could reauthorize that beyond bioterrorism in a budget-neutral fashion. Mr. Sage welcomed input on that.

- Dr. Frieden noted that New York City government had improved performance measurements, and wishes to do so with CDC.
- Dr. desVignes-Kendrick welcomed the opportunity to communities, formerly funded by CDC contracts, to have a more collaborative, shared leadership.
- Outcome performance incentives being considered include lessened restrictions on grantee carry-over funds from one fiscal year to the next.

At the request of CDC, a break/recharge was facilitated by committee member, Dr. Antronette Yancey to stimulate blood flow and rejuvenate all meeting participants.

Research Agenda Workgroup

Dr. Debra Lappin reported the integration of the Health Protection Goals Sub-workgroup with that of the Research Agenda Sub-workgroup, and the change of the latter's name to "Research Guide Sub-Workgroup." The term "Agenda" will be used for shorter-term priorities.

Dr. Robert Galli reported that the Research Guide is the first to present a comprehensive, long-range vision of national and global public health needs. It identifies knowledge gaps and broad research themes for CDC and its partners, provides a platform from which to leverage coordinated federal agency resources, and plans and promotes both intra- and extramural public health research.

A steering group and workgroups gathered CDC and partner input early in the year. A "shorter" research list was discussed in public meetings, as was coordination with CDC partners. A synthesis then mapped research themes to CDC's Health Protection Goals. A draft Research Guide will be published for public review in early fall. A second Federal Partners meeting will be held to discuss broadening the shorter-term goals beyond DHHS. The agenda and steering workgroups will then publish a finalized research guide and distribute it for comment to this Advisory Committee and others.

The public comment draft's table of contents was outlined: executive summary, background, rationale, scope and use, development process, related research; and the components of the guide itself: infectious disease; health promotion; environmental and occupational health and injury prevention; community preparedness and response; health information and services; global health; and innovation and cross-cutting research. Examples of the linkage of the Research and Goals Action teams were outlined for adolescent health, influenza, healthy workplaces and global health promotion.

Health Protection Goals

Dr. Lappin reported two meetings held to discuss how to engage CDC's multiple partners and the public on the prioritization of strategies and objectives. The Subgroup recommended:

- Communicate the "new CDC" simply and directly
- Integrate the research guide and health protection goals
- Support the core work process of the four Trailblazer goals (influenza, asthma, obesity, preparedness) — for these, and probably all the goals, consider new matrices, skills and approaches from other areas to address public health problems. Then consider if these are cost effective, able to prevent a condition, what and who they would involve (e.g., workplace, schools); their likelihood to impact health; any related policy change requirements; research needed; potential marketing; and management implications.
- CDC should explore new online Internet engagement, such as Canada's questions posed online for expert-driven input, and maximally use its partners (e.g., State Medical Directors). Other ideas included the issuance of mini-RFPs and holding stakeholder and public town hall meetings to get their buy-in, or a key constituency conference.

The next phase for this workgroup's advice/input will address how to:

- Share the vision for "CDC Now" and accountability for health impact
- Develop common metrics and mechanisms to measure "health impact"
- Design and launch a rational, transparent plan for timely and meaningful stakeholder engagement, to ensure the external partners see themselves and their CDC partnership in the goals action plans
- Engage new communities in new ways (e.g., at the national PTA meeting on healthy schools)
- Engage federal partners in the research guide's development
- Provide advice to relate the health protection goals to those of Healthy People 2010 (a mid-course review) and Healthy People 2020

Discussion included:

- Perhaps CDC's greatest tool to share is the NHANES data and other data subsets. Dr. Bender urged CDC to find such niches of expertise, then to sort out potential collaborations with major partners and stakeholders to broaden that work.
- To more effectively address health disparities, Dr. Yancey suggested CDC's review of work done elsewhere (e.g., Mexico or Canada) for other possible strategies to reach cultural groups, either here or in their countries of origin. That knowledge could be applied in a mainstream setting even if it is not supported by RCT-level data, as done for tobacco control. This could also help to prevent the continuous funding of activities that do not work. For example, innovative approaches to obesity taken by Mexico included dissemination of tape measures to address the 80% of women developing abdominal fat.
- Dr. Beasley asked CDC to provide a list of its partners, stressing the importance of teaching them what the new CDC is. That is especially important in view of

staff attrition. Particular efforts should be made to inform medical schools, beyond the Deans and Schools of Public Health. He also asked how CDC, assumed to be accountable for Americans' health, would counter the failures (e.g., deaths in an influenza pandemic; continued rise of obesity).

- Dr. Benjamin called for clear directions, reasonable as well as science-based, to be issued to clinicians and individuals to help them not fear this change. In the context of a 24/7 news environment, he termed it "essential" that CDC have a rapid response team in place to deal with public misunderstandings of health issues, so that people can make rational decisions.
- CDC should ensure good coordination with the APHA. Its board voted to start a grassroots campaign to prevent serious health effects among Americans. They are exploring a constellation of concepts, packages, and perhaps legislation to help that. Americans are concerned about their health, but not enough to do anything about it. Non-traditional partners such as business, which is very much engaged in this, need help and should also be involved. Also needed is support for the CDC budget to parallel that of the NIH.
- Dr. Lappin agreed, suggesting the quick formation of a group to assist Dr. Gerberding's public response. She further suggested representation of the Coordinating Centers and other CDC Advisory Committees on the Goals Development Subcommittee (now a workgroup), to provide comprehensive advice for CDC overall and to ensure broader interagency coordination. This broader focus would require the Subcommittee's description to be rewritten.
- Dr. McIlhaney stated that health promotion involving behavior change will always be criticized, as occurred with CDC's obesity message. Nonetheless, CDC must lead, speaking out precisely and loudly, whether through public relations people or others, to effect behavior change.
- Mr. Smith advised CDC to keep the message simple.
- Dr. desVignes-Kendrick urged CDC to go ahead and cite individual responsibility as a component of health (i.e., "you are part of the problem ... and part of the solution to this serious problem that must be addressed"), along with policy makers, schools, etc.). However, this should be part of a holistic approach, acknowledging that there are contributing factors not under individual control (e.g., the lack of a grocery store or ability to exercise after dark in an unsafe neighborhood). Dr. Yancey agreed. The MADD and tobacco control public health successes involved more than promotion of personal responsibility. They required changes in social norms (e.g., from "one for the road" to "friends don't let friends drive drunk"). A whole constellation of things in the societal structure beyond the individual level are necessary to affect the 75% of the population that is obese.
- Dr. Goodman suggested modeling interventions on the successful MADD methods, which made drinking and driving socially unacceptable.

Dr. Gerberding cited the new public health-related activities of the National Governors Association and the AMA as hopeful signs of a new momentum and opportunities for progress.

Ethics Subcommittee

Dr. Marilyn Maxwell reported for the *Ethics Subcommittee*, which is chaired by Dr. Ruth Macklin of the Albert Einstein College of Medicine. The Subcommittee's main charge has been defined as helping to develop CDC's internal capacity to identify, analyze and resolve ethical issues. Its membership and time line of work was outlined. The first priority identified by the internal Public Health Ethics Committee was education, CDC-wide, top-down and bottom-up. The first training will be offered on September 23rd. Consultations were done on research versus practice (non-research) questions and on the HIV Tenofovir clinical trials in Thailand and Botswana (i.e., on issues of needle exchange and informed consent). Individual consultations also were provided on pandemic influenza planning and the MedKits project.

As this is an active working Subcommittee and Dr. Maxwell is its only ACD representative, she invited at least two, preferably three other ACD members to join. It meets quarterly and holds conference calls. Dr. Benjamin volunteered; others will be contacted.

The Subcommittee's next steps include a meeting on September 26th to map the scope of public health ethics and to discuss a public health ethics issue. Dr. Gerberding was formally invited to the Subcommittee's January 2006 meeting, when they will map the overlap of public health science and public health ethics, set their direction for 2006, review their 2005 activities, and discuss educational offerings for the internal committee. In October, a 2 day workshop for the CDC internal ethics committee members will be offered.

Discussion included:

- Dr. Snider appreciated the contributions of the ethics professionals to the discussions; for example, the use of antivirals in an influenza pandemic. Their ability to analyze the relevant considerations and draw possible solutions was very helpful. Dr. Gerberding particularly cited the Committee's help to move CDC beyond an exclusive scientific basis for its prioritizations.
- Dr. Maxwell suggested the addition of an ethical component to CDC's IRB protocol.
- Mr Smith raised the issue of government ethics officials' conflict of interest and bias. These will be taken up by CDC with the Office of General Council to ensure that no problems arise (none have been identified so far). The new OMB requirements for external peer review will also foster a broad perspective, and lack of bias, of CDC documents. Mr. Smith recommended CDC's review of a good document on bias available from Susan Newcomer of NICHD.
- Dr. McIlhaney raised marriage as a vehicle of healthy behavior and health promotion. He asked how CDC could promote that message so that it could be heard without offense by those who are not married or unable to legally marry (e.g., those gay or lesbian). Dr. Maxwell, one of six physicians on the AAP's Task Force on the Family, agreed that the data indicate better overall health outcomes among children in a two-parent family. However, she commented, the

discussions over presenting that information in the AAP published report paralleled the prioritization debate over science versus ethical issues.

CDC Budget

Chief Operating Officer, Mr. William Gimson charted the CDC budget from 2003 to FY06. The current House and Senate FY06 budget overall was straight-lined from that of FY05, as was ATSDR's \$76 million level to the President's FY06 budget. Of CDC's overall \$8 billion budget, estimated increases before the Conference Committee's finalization were:

- Global Disease Detection: +\$13.5 million to total ~\$35 million
- Vaccine Safety: +\$1.5 million (total, \$24 million)
- Youth Violence Prevention +\$1.25 million (total, \$23.7 million)
- PHHS Block Grant: +\$100 million (total)
- SNS: +\$70 million
- Director's Discretionary Fund: +\$4.5 million
- Buildings and facilities: +\$200 million (not an increase; master plan maintenance)

Decreases in FY06 were to:

- Bioterrorism State Grants: -\$95 million
- VERB Program: -\$48 million (leaving \$11 million for FY06)
- Block Grants: -\$19 million (leaving ~\$120 million)
- Business Services: -\$15 million.

A pie chart of the total budget by organization showed 41% of funding going to the CCID, followed by 20% to the COPTER and 14% to the Coordinating Center for Health Promotion. However, when charted intramurally, the funding distribution was more even. Some distributions, such as to the Office of Workforce and Career Development, and the Office of Strategy and Innovation, were so small as to not be charted.

In terms of capital resources, the Building/Facilities master plan from 2000-2009 has an estimated value of \$1.5 billion to construct 13 new buildings in Atlanta, holding ~3 million square feet. Half of the space is laboratory, half supports research. Staff is consolidated on two main campuses. The four new buildings to be opened in 17 days house the most modern Infectious Diseases Laboratory in world, CDC's Communications Center, the Toxicology Lab, and Headquarters for the permanent Emergency Operations Center (EOC). The fourteenth building in the budget will be the Ft. Collins Vector-Borne Laboratory.

Remaining challenges include:

- Competing federal resources. CDC needs to be clear about the value it adds to the mix among federal agencies to justify its yearly inflationary cost of \$25 million. Looking for efficiencies is a daily activity.
- Demonstration of health impact, the only way to compete for funding.
- Stewardship and accountability.

Opportunities include:

- The health impact message is going out and the OMB and Congress are hungry for that information. That metric is needed to support investment.
- The support of partners, stakeholders and advisory committees.
- People: the CDC staff of 10,000 employees and 5000 contractors.

Discussion included:

- Dr. Frieden expected more cuts to block grants, state bioterrorism grants and risk-based allocations. He asked how they could be repackaged to show more direct health impact and preserve those dollars. Mr. Gimson noted the shrinkage in preventive health and health services block grants from a high of \$150 million to the present ~\$50 million. This is discretionary state funding (within some criteria) to support work ranging from chronic disease to EMS services. But great differences in the states' performance measures make it more difficult to support, and the per capita formulae of federal/state contributions are very variable. However, the danger is that an abrupt cut to the block grant will cut critical programs in almost every state.
- Dr. McIlhane suggested emphasis on the fact that prevention saves money as well as alleviates suffering, a message to which Congress responds well.
- Dr. Yancey was concerned over major cuts to one of the four major priority areas, adolescent health, such as to proven programs such as VERB. Such programs need to continue to be able to map the resulting health outcome changes. Mr. Gimson defined VERB as a successful proof of concept that now supports investment in such work. Congress is very interested in adolescent health, but in a broader range than the very focused VERB program.
- Dr. Benjamin recalled that block grants began as a compromise, when a merger of categorical programs included big funding cuts that offered greater state spending flexibility. That kind of adaptation will happen again, but this is still a \$50 million cut. If Congress is not comfortable with the flexible block concept, that needs to be reprogrammed into public health activity that is measurably accountable. Since the states use these dollars for their response to a big range of surge issues, a coherent long-term strategy is needed to avoid another \$100 million cut next year. Dr. Gerberding agreed that accountability is key; showing the value (part of this year's grant performance base) provides a better position of support. While the value of the preparedness grants is very hard to demonstrate, that can be done by showing the shared response value of CDC and the states. Emphasis is needed that those public health preparedness dollars also contribute to daily public health work (e.g., response to foodborne outbreaks, natural emergencies such as hurricanes, etc.).

FACA/CDC Committee Structure

An extended discussion of the CDC Advisory Committee structure under the *Federal Advisory Committee Act (FACA)* was introduced by Mr. Delaney. Of CDC's 25 standing committees, eight are mandated; 14 others are discretionary, to address specific public

health needs. There is no formal connection between the advisory committee structure and the Office of the Director (OD).

Ms. Kathy Skipper, of the Management and Services Office (MASO), described the *current CDC committee structure*. The OD has three committees to advise it: the Advisory Committee to the Director of CDC (ACD); a Special Emphasis Panel convenable to address disease, disability, and injury prevention and control; and the Advisory Committee on Immunization Practices (ACIP). Most of the Centers under each Coordinating Center also have committees to advise on scientific and programmatic/policy matters, as well as mandated committees. NIOSH has four, two of which are mandated.

Dr. Gerberding noted that running the existing committees costs ~\$14 million a year, and yet she receives direct advice from only two. She outlined a proposed structure through which this Committee and its Subcommittees could advise CDC on its accountability, customer service, ethics, goals development, global health, address of health disparities, public health leadership and research. Each entity would have a liaison member to the ACD to ensure cross-communication. Since at least one ACD member must sit on each subcommittee, the members' workload would clearly expand, so its membership may have to expand as well.

To ensure scientific support for the Centers as well as strategic engagement on a broader level, Dr. Gerberding also requested that the Committee examine a comprehensive change in the Committee structure overall. For example, each Coordinating Center could have an advisory committee to oversee the balance of research with science, appropriate customer services, etc., as well as Boards of Scientific Counselors (BSC) to ensure peer review. There is currently no systematic way to assess what work is the state of the art or what needs improvement, and CDC is now legally required to have 100% peer review.

Discussion included:

- Mr. Smith asked if some of the discretionary committees could be dropped. Dr. Gerberding was awaiting the input of the committees involved, but some may simply need to be renamed/redirected to be solely BSC, or sited elsewhere.
- Dr. Beasley noted that technical committees such as the ACIP are the least likely to be served by funneling through the ACD. Those that are more general, policy and strategy-related, should come through the ACD.

A telephone call hookup to 21 other committee chairs and federal officials began (attendees list is attached) to discuss the reorganization of CDC Advisory Committees other than those advising on technical or specific policy issues. The Committees evolved at different times under different Congressional authorities. Their activities need to be consistent with agency needs, accommodate a mechanism for the complete peer review now mandated, and ensure systematic input. Standards are needed to allow consistent interpretation of the BSCs' input across CDC. The progress of each CDC Committee can inform the process, especially for some Centers without an advisory committee.

Discussion included:

- CDC has some flexibility in creating new committees with members presently on others or a sunsetting committee. Backed with a strong consensus from the Advisory Committees, suggestions to Congress also could be advanced if any revamping of authorities is needed.
- The Center-level advisory input includes that on the quality/integrity of research as well as on program functions. Committees like ACIP are not overseen, but ACIP also suggests needed research. There will be no change to ACIP, but comments are welcome in any area.
- Several Chairs outlined their Committee's initial processes to review all programs and offered to share their protocol/criteria and other experience.
- Dr. Nolan noted the complexity of the formal committee setup process. She suggested, as possible, improved communication between the Committees as an alternative.
- Dr. Anderson suggested the use of the NIH Standing Study Section for external peer review and perhaps for the science side of internal peer review. Like many BSCs, NIOSH's provides broad expertise to address program evaluation and, in part, policy, priority setting, etc.; and it identifies experts to conduct the basic science review. Dr. Gerberding identified this as a separate and future issue. As CDC expands its growing extramural research, a peer review mechanism will be needed to achieve the same quality peer review as done at NIOSH, on an ad hoc basis. The NIH models have been reviewed and some could work, but NIH does not conduct the type of programs that constitute most of CDC's work.
- Dr. Frieden urged a flexible system so that if another structure seems to better meet needs, it can be adopted.
- The review of and appointment to Advisory Committees is done at the DHHS level, which has a strong hand in selecting scientists to advise CDC.
- There is no problem of overlap between the existing CDC Committees, but some are complex in structure. For example, DHHS merged HRSA's AIDS Advisory Committee with that of the NCHSTP, so it now is not fully focused on CDC issues.
- The BSCs' role to prioritize new research efforts, identify gaps, and advise on programmatic matters was discussed. The Coordinating Centers need an integrated Advisory Committee to review their strategies, prioritization and policies, but such a Board would be hard pressed to also conduct a comprehensive peer review. Other options include the use of a technically oriented subcommittee or workgroup; linking to the review functions into one overarching committee from subcommittees; or having an advisory committee and BSC at the Coordinating Center level. Coordinating all the Centers' Science Advisory Committees' review of intramural research will be a challenge, and their comments on the science or program policy will impact the direction of research (if not the review of that research). How they would weave together was discussed.
 - ▷ The NCID BSC, which advises on both priority setting and peer review of intramural programs and science, has discussed expanding its role to advise the Coordinating Center. All the other Coordinating Center Advisory

Committees were invited to discuss that, and perhaps having liaisons between each.

- ▶ The ad hoc committees that conducted various reviews last year could not be used. The FACA process is required to provide CDC with consensus recommendations, and it requires lots of management and logistical supervision. Simple input can be obtained through the workgroup process, but that cannot be used to get specific recommendations.
- ▶ The additional advisory groups are needed at least to provide external peer review to the Centers with no such mechanism. Another mechanism is needed to ensure greater integration and a more comprehensive look at CDC areas that have not been reviewed to date. For example, the NCCDPHP only has the Breast and Cervical Cancer Prevention Advisory Committee, and needs to help review, prioritize, and examine investments in its portfolios.
- ▶ Other approaches suggested included:
 1. Having 3-4 Center Advisory Committee members meet with other experts (e.g., on TB-related extramural research) to provide information on the projects to the overall Advisory Committee, BSC, etc., for its review and official recommendation to CDC. This is similar to the intramural research review done by FDA's CBER Advisory Committee, VRBPAC. VRBPAC assigns one member and two subject matter experts to review the work in a particular CBER lab, and to comment on its adequacy of resources, relevance of the research for CBER's mission, etc. They report back to the BSC, which then advises on any actions needed.
 2. BSC subcommittees could address research gaps and priorities and carry back that information to the BSC for action.
 3. As done at NCID, have a broader Advisory Committee at the Coordinating Center level and a more focused BSC in the CIOs. Specifically, the BSC would assure the science basis of the program by reviewing its intramural science at the Coordinating Center level. Issues of integration, policy and prioritization are increasingly relevant, and now, as CDC evolves its goal action plans, it will need specific advisory committee review of the big picture of CDC activity to accomplish health impact. Comprehensive advisory committee input from the Coordinating Center level is needed for that.
- ▶ Neither of the two new Centers (Public Health Marketing and Public Health Informatics) has a BSC. A BSC's knowledgeable input could help answer the critical need to build up the science infrastructure of those two areas, which are acknowledged sciences in academia.

Dr. Gerberding proposed that an ACD member work with other advisory committee representatives to draft recommendations to accomplish this guidance to CDC, without overburdening everyone and breaking the budget with more committees. She asked them to develop options for comment by email or phone call from existing committees and CDC programs. Mr. Smith volunteered. Those on the phone were asked to advise Mr.

Delaney as to whom on their Committee would participate (Mr. Delaney will follow up with an emailed reminder in the next day or so), and to provide an update on how the individual Committees are approaching the committee process.

Dr. Valdiserri suggested that all committee members be alerted to this process, that the committee DFOs use parallel language to describe it and the next steps, and that the results be shared electronically.

ACD Structure

Health Disparities

Dr. Walter W. Williams, Director of the Office of Minority Health and Health Disparities led the health disparities topic. CDC's Health Protection Goals are framed around goals to: 1) provide people with optimal health quality over their life span, 2) ensure preparedness to protect people from health threats, and 3) ensure that the places where people live, work and play promote health. Dr. Williams discussed enhancing CDC's impact on reduction of health disparities related to ethnicity, race, gender, socioeconomic status, etc. He described an FY 2004 inventory of CDC's current health disparity activities, including 50 research and assessment initiatives, 25 prevention initiatives, nine related to the workforce, and 29 targeting education and outreach.

The formation of an ACD Health Disparities Subcommittee was proposed. The proposed membership would include 2-3 ACD members and others to provide multidisciplinary representation. The following functions were proposed: advise the ACD and agency on CDC's health disparity reduction efforts; support the development of related objectives, performance indicators and priorities; advocate for action on health disparities; and provide guidance on collaborative opportunities with other sectors.

Discussion included:

- Mr. Smith asked what the likely composition of the Subcommittee would be (e.g., size, members' background, etc.)? Dr. Williams responded that critical federal partners would be consulted as liaisons and that public partners have been listed. There is no total subcommittee number decided at this point, other than the 2-3 ACD members. The subcommittee could include up to 15-20 other partners who would not only comment, but also participate materially in specific areas where CDC currently has less expertise (e.g., rural health issues). Among those who are being considered for a federal liaison role or participation on the subcommittee, some of whom already involved in some area of health disparity, are individuals and members of the AHRQ, NIH, CMS; the Kellogg Foundation, Commonwealth Fund, National Rural Health Association, American Association on Health Disability, Association for American Indian Physicians, National Hispanic Medical Association, and many others. Individuals have also contacted CDC expressing interest.
- Dr. Gerberding added that the primary goal is to tap technical expertise and, more likely here than in other areas, to gather more public input. While NIH has a

separate committee of public advisors to review the public involvement in its work, she worried that having 18 people to “represent the public” may be no more helpful than having two.

- As the Health Disparities Subcommittee would be a working committee, its size could be increased as needed to do the work. Consultants and contractors could also be hired, but the Advisory Committee process is more open and transparent. The expertise represented also can be phased in as the board membership changes over time.
- Dr. Benjamin reported that the data on disparities that he reviews daily is extraordinarily compelling. It is a huge and growing issue that will require a subcommittee’s attention.

Dr. Bender applauded the greater involvement of this committee in CDC’s work. And, having seen health differences he did not understand among his own GM employee population, he wanted to know the differences in their communities. He called the question and **moved to create an ACD Subcommittee on Health Disparities**. The motion was seconded by Dr. McIlhaney and, with all in favor, the **motion passed unanimously**.

Other committees

Dr. Gerberding then raised the other proposed subcommittees, to address global health, public health leadership, customer service, and accountability to oversee CDC’s management and efficiency from a business perspective.

Discussion included:

- In part, the difference between workgroups and subcommittees is in their longevity. The workgroup handles one issue and is dissolved, while subcommittees work over a longer period of time. The subcommittee process is also more open.
- Dr. Lappin noted the importance of the proposed Goals Development Subcommittee and thought it a good place to assemble the new Coordinating Center advisory committees in one overarching committee. Its charge should be to provide comprehensive advice for CDC overall, although from the Coordinating Center perspective, in order to ensure broader interagency coordination. The membership should not be limited to the Coordinating Center representatives.
- Dr. Bender volunteered to work on these subcommittees to support the new CDC vision. Dr. desVignes-Kendrick also volunteered, and added that some of the present committees and subcommittees could perhaps be merged into those suggested. Dr. Benjamin agreed that some need lumping and others will have less to do. Drs. Bender and McIlhaney agreed to work with Dr. desVignes-Kendrick on the whole issue of committee-subcommittee structure, to recommend on whether additional subcommittees would be needed, particularly in areas of less depth in CDC.
- Dr. Yancey volunteered to participate on the Health Disparities Subcommittee.

- Dr. Beasley suggested adding the word “values” to the Ethics Subcommittee, and volunteered to work on the Global Health and the Research Subcommittees.

Dr. Galli observed that, once the total number of committees is decided, the ACD membership needed can be addressed. Other CDC advisory committee members also can be invited to participate. The members will be asked to volunteer for those subcommittee and workgroups, and the appropriate assignments will be made by the committee Chair.

Public Comment

Public comments were solicited, to no response.

Closing Comments

Dr. Gerberding appreciated the subcommittee process’ present value in helping to change the agency. CDC will proceed with the ACD’s support. She urged the members to communicate with CDC at any time, including with her directly by phone or email, or with Mr. Delaney, who will ensure she gets back to them. She asked for candid communication, even if the comment is negative or critical. She provided her contact information: 404-639-7000 from 8 a.m. to 7 p.m. EST. The email addresses are jgerberding@CDC.gov or, for Mr. Delaney, rjdl@CDC.gov. He asked that he be copied on all correspondence.

Mr. Smith recommended that all the members come to the building openings on September 12 and Dr. Galli thanked everyone for their input. With no further comment, the meeting adjourned at 3:30 pm.

Attachment 1: Attendance

Julie L. Gerberding, M.D., M.P.H., Director, CDC

Robert Delaney, Executive Secretary, ACD and Chief of Staff, CDC

Committee Members present:

- *John O. Agwunobi, M.D., M.B.A., M.P.H., Committee Chair, Secretary of Health and State Health Officer, Florida Department of Health, Tallahassee, FL*
- *R. Palmer Beasley, M.D., Dean Emeritus, Ashbel Smith Professor of Epidemiology, University of Texas/Houston Health Science Center, Houston, TX*
- *Joel Reed Bender, M.D., Ph.D., M.S.P.H., Corporate Medical Director, General Motors Corporation, Detroit, MI*
- *Georges Benjamin, M.D., F.A.C.P., Executive Director, American Public Health Association (APHA), Washington, D.C.*
- *Mary desVignes-Kendrick, M.D., M.P.H., F.A.A.P.; Professor and Deputy Director, Center for Biosecurity and Public Health Preparedness, University of Texas School of Public Health at Houston, TX.*
- *Thomas R. Frieden, M.D., M.P.H., Commissioner, New York City Department of Health and Mental Hygiene, New York, NY*
- *Robert L. Galli, M.D., Professor and Chair, Emergency Medicine, University of Mississippi Medical Center, Jackson, MS.*
- *Jay Goodman, Ph.D., Professor, Department of Pharmacology and Toxicology, Michigan State University, East Lansing, MI*
- *Debra Lappin, J.D., Senior Advisor, B&D Sagamore, Englewood, CO*
- *Marilyn M. Maxwell, M.D., Associate Professor of Internal Medicine, St. Louis University, St. Louis, MO*
- *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, M.D., M.P.H., F.A.C.P.M., Associate Professor, University of California in Los Angeles, School of Public Health, Los Angeles, CA*

Members absent:

- *Joseph M. Hogan, President and CEO, General Electric Medical Systems, Waukesha, WI*
- *Sandra K. Mahkorn, M.D., M.P.H., M.S., Chief Medical Officer for Health Information, Division of Health Care Financing, Wisconsin Department of Health and Family Services, Madison, WI*

CDC staff present:

Tim Baker
Jay Bernhardt
Blake Caldwell
Thayes Carswell
Daneen Farrow-Collier
Jeff Cook
Cecilia Curry
Jan Devier
Avis D. Dickey
Jim Down
Henry Falk
Jennifer Farnsworth
Sheryl Gagnon

William Gimson
Crystal Gresham
Rima Khabbaz
Lonnie King
Ruth Martin
Reggie Mebane
Priscilla Patin
Larry Pickering
Michael Sadagurski
Mike Sage
Katie Shebesh
Don Shriber
Tom Sinks

Dixie Snider
Bob Spengler
James Stephens
Ray Strikas
Stephen Thacker
Ed Thompson
Tim Uyeki
Richard Schieber
Rubin Wagner
Walter Williams
Michelle Wilson

Others present:

Diana Feld, Professional and Scientific Associates, Atlanta, GA
Marie Murray, Recorder, Atlanta, GA

Conference call participants:

Jon Abramson
Henry Anderson
PJ Brennan
Gwendolyn Cattledge
Steve Cochi
Louise Galaska
Marjorie Greenberg
Crystal Gresham

Philip Harber
Marilyn Horton
Jack Jackson
Mary Kate Weber
Jeffrey Kohler
Jesse Milan
David Momrow

Patricia Nolan
Dana Shelton
Patricia Simone
Lou Turner
Ron Valdiserri
Robert Weinzimer
Debra Younginer

CDC Conference Call Attendance

Jon Abramson
Henry Anderson
PJ Brennan
Gwendolyn Cattledge
Steve Cochi
Robert Delaney
Louise Galaska
Marjorie Greenberg

Crystal Gresham
Philip Harber
Marilyn Horton
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Jesse Milan
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Attachment #2: Specific ACD Input, August 2005 meeting

Consensus. Nods around the table indicated consensus to the proposal that a formal workgroup be formed to discuss CDC's work on HIV/AIDS and related strategies, to report back to the full committee for discussion.

CDC Goals Development/Staff

- Dr. Frieden asked that the January-March CDC goals review phase include sharing the goal action plans for advisory committee comment.
- Dr. Agwunobi suggested development of a life stages map based on science for communities as well as individuals.
- Dr. McIlhaney suggested development of a very succinct life plan/"vision" for Americans (i.e., "follow this plan of activity and you'll be healthier on the day you die.")
- Ensure good coordination with the APHA, whose board voted to start a grassroots campaign to prevent serious health effects among Americans. They are exploring a constellation of concepts, packages, and perhaps legislation to help that.
- Further reports on CDC staff and morale will be provided at the next meeting.
- It is essential that CDC have a rapid response team in place to deal with public misunderstandings of health issues in the context of a 24/7 news environment, so that people can make rational decisions. The quick formation of a group to assist Dr. Gerberding's public response was suggested
- The Goals Development Subcommittee should have representation of the Coordinating Centers and other CDC advisory committees, to provide comprehensive advice for CDC overall and to ensure broader interagency coordination. Its description will need to be rewritten to such a broader focus.
- CDC must lead to effect behavior change. Keep the message simple. Behavioral change interventions could model on the successful MADD approach. CDC should go ahead and cite individual responsibility as a component of health (i.e., "you are part of the problem ... and part of the solution to this serious problem that must be addressed"), while maintaining a holistic approach that also acknowledges contributing factors beyond individual control (e.g., neighborhood safety or amenities). Involve non-traditional partners such as business as much as possible. They are very much engaged in this and need help.

CDC budget and avoiding cuts:

- Dr. McIlhaney suggested emphasizing the fact that prevention saves money as well as alleviates suffering, a message to which Congress responds well.
- If Congress is not comfortable with the flexible block concept, it needs to reprogram that into public health activity that is measurably accountable. Since the states use these dollars for their response to a big range of surge issues, a coherent long-term strategy is required to avoid another \$100 million cut next year.

CDC committee structure:

- Dr. Frieden urged a flexible system so that if another structure seems to better meet needs, it can be adopted.
- Mr. Smith volunteered to work with other advisory committee representatives to draft recommendations to accomplish this guidance to CDC, without overburdening everyone and breaking the budget with more committees. They will develop options for comment by email or phone call from existing committees and CDC programs. Those on the phone asked to advise Mr. Delaney who on their committee would participate (Mr. Delaney will follow up with an emailed reminder in the next day or so), and to provide an update on how the individual committees are approaching the committee process.
- Dr. Valdiserri suggested that all committee members be alerted to this process, that the committee DFOs use parallel language to describe it and the next steps, and that the results be shared electronically.

Motions:

Dr. Bender **moved to create an ACD Subcommittee on Health Disparities.** The motion was seconded by Dr. McIlhaney and, with all in favor, the **motion passed unanimously.**

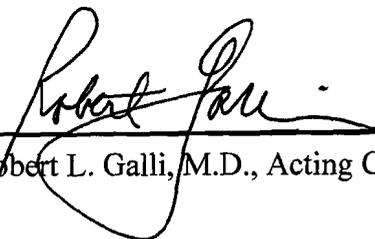
Subcommittees on which ACD members volunteered to serve:

- Ethics Subcommittee: Dr. Benjamin
- Drs. Bender and McIlhaney agreed to work with Dr. desVignes-Kendrick on the whole issue of committee-subcommittee structure, to recommend on whether additional subcommittees would be needed, particularly in areas of less depth in CDC.
- Health Disparities Subcommittee: Dr. Yancey
- Ethics, Global Health, and the Research Subcommittees: Dr. Beasley

Other:

Mr. Delaney asked that he be copied on all ACD correspondence

I hereby certify that the foregoing summary of the Advisory Committee to the Director, Centers for Disease Control and Prevention (CDC) meeting held on Thursday, August 25, 2005 is accurate and complete to the best of my knowledge.



Robert L. Galli, M.D., Acting Chairman

12-10-05

Date