



**Advisory Committee to the Director
Centers for Disease Control and Prevention
Roybal Campus, 1600 Clifton Road, Atlanta, Georgia 30333
Global Communications Center, Building 19, Auditorium B**

**MEETING SUMMARY
February 23, 2006**

Department of Health and Human Services
Public Health Service



Acronyms used in this report

BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CCHIS	Coordinating Center for Health Information and Services
CCEHIP	Coordinating Center for Environmental Health and Injury Prevention
CoCHIS	Coordinating Center for Health Information and Services
COTPER	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
DoJ	Department of Justice
FACA	Federal Advisory Committee Act
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
NCHM	National Center for Health Marketing
NCHSTP	National Center for HIV, STD and TB Prevention
NIH	National Institutes of Health
NAS	National Academy of Sciences
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCPHI	National Center for Public Health Informatics
NCHS	National Center for Health Statistics
NCHSTP	National Center for HIV, STD and TB Prevention
NHANES	National Health and Nutrition Examination Survey
NGO	Non-Governmental Organization
OD	Office of the Director
OMB	Office of Management and the Budget
SME	Subject Matter Expert
STD	Sexually Transmitted Disease
VFC	Vaccine for Children (Program)
YRBS	Youth Risk Behavior Survey

**Centers for Disease Control and Prevention
Advisory Committee to the Director
Record of the February 23, 2006 Meeting**

A meeting of the Advisory Committee to the Director (ACD) of the Centers for Disease Control and Prevention (CDC) was held on February 23, 2006, at CDC headquarters in Atlanta, Georgia. The meeting was convened at 8:34 a.m. by Dr. Lynn Austin, ACD Executive Secretary and CDC Chief of Staff. Dr. Robert Galli was Acting Chair for this meeting. The attendance of ACD members and CDC staff is listed on Attachment #1.

State of the CDC. The new draft State of CDC Report was distributed to the ACD members. CDC's strategy follows two paths: achieving optimal health impact for Americans and response to urgent threats, whether natural or man-made. The framework for present and future work was outlined through five aligned strategic imperatives of CDC work: Research, Health System Leadership, Individual and Global Health, and CDC Accountability.

Dr. Julie Gerberding, Director of CDC, outlined present and possible future CDC work through five scenarios.

Protecting Health in an Era of Terrorist Attacks (biological, chemical, radiation, explosives). CDC's portfolio and budget already reflect the increasing dominance of homeland security in national policy and funding decisions. Much of CDC's budget supports terrorism response and pharmaceutical stockpiling, global AIDS, and immunization (global and the domestic VFC program). There are very worrisome funding declines in other core public health functions, such as occupational safety, injury prevention (the leading life-stage cause of death) and STD prevention. Stronger relationships between HIV and STD programs are being affected, but historically, dropping disease rates and waning attention have produced outbreaks. CDC now must find ways to balance all the necessary work, especially in health areas not addressed elsewhere (e.g., STD tracking), particularly as state public health budgets similarly decline.

Public Health will "go personal". Employers are shifting the cost of health insurance to employees, giving the latter more incentive to protect their own health. The value of disease and injury prevention is advanced through CDC's life stage approach to health, from infants to seniors. A shared framework outlined the adolescent goal action plan development process by the CCEHIP goal action plan team. It receives input from internal and external SMEs, is reviewed by committees, partners and the public; is finalized, implemented, and then evaluated with performance measures.

Shifting Roles of Public Health. With the rise of health information technologies (HIT) such as portable, personalized electronic health records (EHR), CDC's focus will shift from data acquisition to data management, and some of this could be outsourced to other agencies. Governmental and academic public health organizations will be marginalized

by drastic budget cuts; traditional public health functions will be assumed by large healthcare organizations and private sector entrepreneurs. Population health status will be electronically monitored through EHR and interoperable HIT systems. Acute health emergencies will be handled by the Homeland Security Force and first responders.

Global Health. CDC shares its knowledge, tools and resources globally. A transnational, global disease prevention, detection and response network (GDD) in development will be established. Three GDD and response centers will be in each of the WHO's six regions. They will include quarantine stations, field epidemiology, laboratory training, and new sentinel and Laboratory Research Network sites. International business connectivity will be leveraged for greater surveillance sensitivity. The GDD program will share data with CDC's BioSense and Biointelligence centers, which hold federal, commercial and private clinical care data. CDC will have the most far-reaching and comprehensive health surveillance system in history, which will help foster good U.S.-foreign relations through CDC's role as "health ambassador."

Universal Access to Health Insurance. Unsustainable U.S. health system costs have already led to changes such as health savings accounts. A shift must occur from treatment of complications (95% of U.S. health care expenditures, 50% spent at life's end) to health promotion through all life stages, an investment CDC promotes. An optimal benefit plan would fully cover health promotion and proven primary preventions, and provide incentives for adopted healthy lifestyles and avoided risk behaviors. The life progression then would go from safer, healthier people (general protection), to increasing vulnerability with age (targeted protection), to affected people without complications (primary protection) or with complications (secondary and tertiary protection). Getting there is a challenge in the reality of annual budget cycles, but everyone has a stake in the needed changes to the system.

Discussion included:

- Dr. Joel Bender concurred with the five outlined scenarios, and particularly the attention to the impending health crisis of our aging population. Even GM's rich benefit plan cannot do what is needed to reduce chronic disease; the obesity epidemic is spreading; and no one entity can deal with these crises alone.
- CDC has contributed to the development of Medicaid's plans to ensure adequate attention to the needs of seniors. But it has not done the sophisticated analyses needed for CDC to be a participant in such high-level policy decisions as the transition away from business-sponsored health care to such personal healthcare arrangements as HSAs.
- The impact on programs such as TB or STD prevention has been amplified by the similar resource losses at every layer, from federal to local. Such traditional health functions will dry up without funding. While public/private partnerships or CDC's provision of technical information and support could fill some programmatic gaps, it is hard to imagine other scenarios through which such traditional frontline issues could be handled.

CDC FY06/07 Budget. A report on CDC's budget was provided by Chief Operating Officer, Mr. William Gimson. The FY06 cut to CDC's discretionary funding, the first since 1981, was paralleled in NIH and HRSA. Of CDC's \$8 billion, half goes to specific allocations. The budget process was charted, as were the FY06 increases and decreases (see Attachment #2). Decreases included the block grant and eliminated CDC's low-impact programs (e.g., Alzheimer's, Tourette's, lupus) where low funding made major health impact unlikely.

A new CDC Management Council was formed to coordinate the critical broad areas of CDC operation and ensure that financial strategies emphasize the health protection goals. Key performance indicators were established for all business offices, and consolidation of services saved millions. The current budget includes \$15 million found in "excruciating" searches netting \$10,000-\$15,000 at a time, and asking the Centers to "realign" 4% of their dollars. But that was necessary to support aspects critical to CDC work, such as workforce and leadership development, public health research, and execution of the Goals Action Plans. This clearly shows how little of the \$8 billion budget is flexible.

Four new state of the art buildings were opened on the CDC campus. CDC's new structure of eleven more efficient organizations produced a combined savings of >\$40 million, making CDC the first agency to win OMB's High Performing Organization award. Mission-direct positions (550) were filled and ~100 administrative assistant positions were combined or reduced. A Chief Diversity Officer was appointed to direct a new agency-wide diversity plan. A succession planning initiative was developed and individual learning accounts (\$1000/year for training, not travel) were established for all CDC employees to advance staff career development. New CDC portfolio management officials in eight states will provide a single contact point to ensure that efficiencies are leveraged. This will reduce the processing time in general as well as help the states' pilot program to move 5% of their categorical terrorism funding (channeled through CDC) to other critical areas of state needs that also meet CDC's goals.

Discussion included:

- Decreased funding spurs greater efficiencies, but CDC remains challenged by having half of its budget earmarked. To fill identified gaps in the science, CDC is working with NIH as possible, but more is needed. Dr. Friedan emphasized the full ramifications of this, since core public functions left undone (e.g., TB control) will incur greater cost later, and the U.S. already massively under-invests in public health. He quoted the comment 100 years ago, that "public health is purchasable within natural limitations; the public can always purchase its own death."
- While appropriations limit discretionary funding, CDC has negotiated to fund 10% of its portfolio from other federal agencies, and the technology transfer staff keeps looking at new innovations. Mr. Smith suggested that the things the public sees, they might be willing to support, such as a check box on tax forms to contribute to response funding.

Update on Pandemic Influenza. A sobering update on pandemic influenza was provided by Dr. James LeDuc, CDC's new Coordinator of Influenza Activities. He described CDC's planning for, essentially, a repeat of the 1918 H1N1 pandemic. The H5N1 avian flu has spread through Europe and its arrival here is only a matter of time. He mapped the genetic changes of the H5N1 hemagglutinin from the 1995 Hong Kong outbreak to the present day. The Vietnam 2004 viral construct is being used as the basis of the vaccine now in trials, but it poorly prevents one of the two virus clades. The virus is very much a moving target, which makes monitoring critical.

CDC's GDD and other collaborations with the WHO and other international entities will establish frontline detection and response, but upon human-to-human spread, the virus will be unstoppable. Only slowing its spread to decrease illness and death will help, to buy time during vaccine development. Those with flu will receive antiviral treatment; they and those exposed will be quarantined; travel advisories will be issued and entry/exit travel screening may be necessary. Social distancing to avoid contagion will be the order of the day.

Clear communication to the public and advice to prepare now is important. Already in FY06, \$200 million has been spent to build lab capacity and research; link public health with domestic and international disease surveillance; monitor the human-to-animal interface; and prepare for quarantine and diagnostic test development. Another \$350 million has gone to help the states prepare and another \$250 million will follow by year's end, based on population and preparedness performance to date. Linking seasonal flu and increased routine vaccination will drive the increased vaccine production that is expected next year. Increased demand is hoped for as well.

Summits/Checklists. Dr. Toby Merlin, Acting Director, Division of Private and Public Partnerships, National Center for Health Marketing (NCHM), outlined the state and territorial checklists that have been developed to assist preparedness. Pandemic flu summits, planned for every state and territory, will issue a call for action and clarify the responsibilities of multiple sectors (e.g., business, public health, the faith and NGO communities; federal, state and local agencies). Pandemic flu checklists have been released for all sectors, individuals and businesses. Those pending are for the prison system and facilities, social service agencies, and police departments. CDC is collaborating with the American Indian nations on their plans. The checklists will be backed up by tool kits, all Web-based and developed with SME input.

Discussion included:

- H5N1 has a broad host range, but at this point of spread, CDC's concern is now more about its geography. No one knows what happened to the biology/interaction of birds to make this virus so virulent, nor are there data to determine if the antigenic mutations parallel those for virulence. There have been repeated and worrisome episodes of transmission to domestic and wild animals (e.g., tigers fed chickens). However, while the likelihood of mammal-to-mammal transmission remains unclear, the reconstruction of the 1918

pandemic flu virus revealed an alarming similarity to this virus' behavior in mammals.

- Dr. Bender commended the usefulness of CDC's new structure to advancing its work, particularly useful to address pandemics and international work. The GDD platforms, such as the one in China, will be important.
- Questions were raised about the potential for vaccine production upon strain identification, related liability and injury compensation, and stockpiling/shelf life issues. The Emergency Supplemental Bill includes some liability protection. The manufacturers are beginning domestic production of Tamiflu® and are making significant investments to expand egg production for the current vaccine technology. But the egg-based scaling capacity remains unknown, and the move is on to change cell based production.
- Both policy and production are challenged by whether or when to shut down flu seasonal vaccine production, to begin making vaccine for this emerging strain, and when to use it (mindful of the swine flu controversy). Other issues include scarce resources and the societal/ethical implications of such decisions. CDC is incorporating a citizen perspective to the medical decision model.
- Quarantine issues are still being discussed, but would probably only be useful for the first cases. Dr. Bender reported GM's plan to screen returning employees as was done for SARS. Those with symptoms will be instructed to stay where they are and consult a physician.
- Expressing his frustration at not being able to ask many important, related questions, Dr. Palmer Beasley suggested holding an ancillary meeting for those interested. He was particularly interested in the human infections, other than the severe and hospitalized cases, to better assess the range of infection severity or asymptomatic infections. Dr. LeDuc reported intense work to determine that, a very serious knowledge gap. For avian flu, CDC is also changing from its traditionally more strategic and less operational role, to an operational level of preparedness. It also is complementing its less visible field and support work to place staff more visibly in the states. Awareness of the agency is also rising from such work with a broader set of partners.

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

Partnership Strategy. CDC partnerships were described by Dr. Jay Bernhardt, Director, NCHM. Over 1000 partnerships with the business, health care, government and community sectors provide CDC with wide reach. The related challenges involve coordination and ensuring agency-wide consistency with hundreds of diverse partners with narrow interests. The function of NCHM's Division of Partnerships and Strategic Alliances was outlined, which includes conduct of a partnership needs assessment. A Web portal will soon be launched, a Partners Meeting is planned for March, and a best practices partner "playbook" is in development. In *discussion*, Dr. Bernhardt agreed to inform Mr. Shepherd Smith of the nodal organizations (faith sector and others) found by CDC that may be able to help deliver Gulf Coast relief.

Research Agenda Steering Sub-Workgroup. Dr. Galli reported on work to finalize CDC's new Health Protection Research Guide. Literally hundreds of people, internal and external to CDC, are involved. The Guide will address long range research needs (to 2015), identify teams to compile the actual agenda and, hopefully, bring resources. A draft starter list was developed, meetings were held with public and federal partners, and after public review and comment, seven research area categories were identified: chronic diseases and disabilities; infectious diseases; preparedness; safe places to live, work, learn and play; partnering to build a healthy world; managing/marketing health information; and cross cutting research.

The Guide is almost done. Additional comments will be shared with CDC's center directors, advisory committees and the collaborating federal partners, to develop CDC's research agenda. This document is a broad guide to build the breadth of potential research in public health; with the input above, CDC leadership will decide on the final agenda. Science, resources, and public health needs will dictate what areas are addressed and in what order.

Discussion included:

- Dr. Sandra Mahkorn reported clear calls in the comments received for the federal agencies' coordination. She recommended the ACD's approval of the Guide, either on this day or after review of the latest revision.
- Dr. Jay Goodman observed that not all the topics suggested by the public were appropriate for CDC (i.e., some were redundant to NIH work). The Guide will explain that its response to comments. Dr. Mary desVignes-Kendrick supported a clear response, noting that the comments indicate public perceptions.
- Dr. Georges Benjamin advised CDC to promote this Guide at the APHA annual meeting. CDC should also emphasize that this is a national public health research agenda, which differs from a national bioresearch agenda. Dr. Gerberding suggested calling it a National Health Protection Research Guide, with CDC as the clear process leader, but not the "owner."
- Mr. Smith asked about basic standards of research, particularly for that conducted internationally. Dr. Gerberding agreed to the importance of that, which will be addressed through a different document. Dr. Dixie Snider elaborated that the Guide identifies knowledge gaps to be filled. That will be reviewed by the Goal Action Teams, to develop their action plans, and by the Federal Partners Meeting, to identify the knowledge gaps and those willing to address them. CDC's Office of Strategy and Innovation and the Office of Public Health Research will work to coordinate CDC's own standards and ensure the quality of all the research to be done.

Ethics Subcommittee. The Ethics Subcommittee report was provided by Dr. Marilyn Maxwell. She and Dr. Benjamin are the ACD liaisons to the subcommittee. Its charge is to help CDC develop its own internal capacity to identify, analyze and resolve ethical

issues that may arise, and to provide practical counsel on ethical aspects of CDC work. The subcommittee also meets jointly with CDC's internal Public Health Ethics Committee (PHEC).

Subcommittee activities to date include formation of a smaller steering group, four topic-specific sub-workgroups, and preparation of working definitions and goals for public health ethics at CDC. They briefed Dr. Gerberding, collected ethics case studies, held an ethics seminar (February 17), and developed education plans. They plan to develop a conceptual white paper to: 1) define public health ethics as the analysis and application of values, principles, and rules to agency and professional decisions and actions; and 2) relate this to CDC's infrastructure. This will be coordinated with the PHEC. Next steps include the development of related core documents, holding a consultation on the ethical issues of pandemic influenza, and educating the committee and all of CDC on ethics in public health.

Discussion included:

- Dr. Gerberding appreciated the importance of this work and thanked the ACD and subcommittee for advancing it. Educating everyone on these issues will be important to public health as well as to CDC.
- Dr. desVignes-Kendrick agreed to the need of an ethical approach as agencies progress and optimize efficiencies. She advised CDC to "trust but verify" with measures that show the alignment between ethics and work, and to reinforce what is done well. She also commented that aligning ethics with CDC's mission applies as well to what it does not do.
- This approach focuses on programmatic and research areas. Other ethical review procedures, under CDC's Ethics Officer, address such areas as financial impropriety and governmental ethics.

HIV Workgroup. The activity of the ACD HIV Workgroup was outlined by Mr. Shepherd Smith. He and Drs. Marilyn Maxwell and Joe McIlhaney met with CDC on the previous day to discuss why HIV rates in the U.S. were rising (Whether this was caused by antiviral treatments extending the life of those with HIV or if new HIV incidence was actually seeing a rise). CDC described their shift to addressing HIV as an STD rather than a separate disease, with the agreement of AIDS organizations. All states will soon routinely report HIV testing, and partner notification and partner reduction are gaining acceptance ("HIV Stops With Me"). Some legislative changes will be needed to address issues of consent and confidentiality. Evaluation will be more emphasized to indicate best practices and why they work. Better measurement and markers are needed to guide resources to the most effective activities. Both domestically and internationally, targeted messages emphasize the benefits of abstinence or fidelity; where that is not accepted, condom use is promoted. Remaining issues of concern included racial disparities in disease rates, underlying behavioral factors, and remaining stigma. An unintended consequence of successful antiviral treatments is a diminished sense of HIV's danger and importance. Those messages must continue, and the complex personal and social issues must not distract from a focus on the underlying issues of risky behaviors.

Discussion included:

- Dr. Maxwell supported normalizing the HIV test. That will make it more acceptable, help to identify the 25% of new cases that occur among people who remain unaware of it, and could change the behavior that is the root cause of transmission. But she also noted that populations with high HIV seroprevalence will not always be protected even by limiting partners.
- Dr. Mahkorn asked if FDA had just approved an HIV home-test, but that question could not be answered at this meeting. Dr. Bernhardt agreed to check.
- Dr. Frieden applauded the continuation of HIV discussion, since the resource issues continue. In 2005, New York City found one new case for every ten contacts of an HIV-positive person, a good ratio. Only public health does that kind of difficult work, to which there also are no longer any legal barriers. Remaining barriers in New York, though, include required written consent for testing and needed link to care for those tested. A year after testing, $\geq 25\%$ have no care.
- Dr. Gerberding acknowledged the synergism of STD and HIV partner tracing, but the \$93 million is only for testing, not for the follow-up work engendered. Dr. Benjamin stated that routine screening requires vast resources, and adequate partner notification also requires an infrastructure. He cautioned that communities' cultural characteristics demand attention. For example, African American MSM may not consider themselves gay or bisexual, which radically affects informing a woman that her husband or partner infected her. Black communities' social disavowal of gay people has also resulted in many homeless infected people.

Federal Advisory Committee Act (FACA) Structuring Report. Dr. Austin outlined the structure and rationale of CDC's advisory committees. The infrastructure for these and for Boards of Scientific Counselors (BSC) has been inconsistent: some Centers had one or both, or none. CDC is considering several changes:

- Establish advisory committees to the Coordinating Centers, to review Center strategies and priorities and programmatic issues.
- Establish BSCs to provide technical input, focus on the research agenda and related science, and oversee intramural and extramural peer review.
- Establish a new Study Section on Public Health Research to address agency-wide initial extramural peer review.
- Establish additional ACD subcommittees to focus on CDC's strategic imperatives (e.g., customer centricity, financial management).

An internal workgroup supported all these changes except the additional ACD subcommittees, whose work they felt could be done by ACD workgroups. However, keeping the Ethics and Health Disparities Subcommittees was supported. A phased approach to the restructuring was advised, since some committees have natural ending dates. The present committee Chairs and their DFOs expressed concern about the very broad expertise needed to advise the scope of Coordinating Center work and the breadth of the Study Section; the risk of greater attention paid to one issue than others under the

Coordinating Center umbrella (e.g., HIV versus TB); unreasonable time demands of having committee Chairs serve as liaisons on multiple committees; and the cost of adding new committees without eliminating some.

Discussion included:

- To ensure feedback to the Director, each Chair should be required to provide a one-page report of the committee's actions or plans. Term limits for both members and committees are already set for formal FACA committees.
- This year, the government will spend \$250 million on these advisory committees, of which CDC's share is \$11 million.
- Dr. Snider stressed the importance of this process to CDC's scientific credibility. This also affects CDC-funded academic research. Currently, ad hoc review panels are set up for every new Request for Application. One large Study Section probably would be sufficient for CDC's research portfolio, would also more efficiently peer-review extramural research, and could ensure consistent intramural research quality and avoid drift. Dr. Beasley agreed and felt the field would welcome this.
- Dr. Goodman's vision of a small BSC (3 members), with ad-hoc SMEs regularly invited to help review the science, is what is planned. The BSC would not conduct, but would oversee, SME peer review. CDC is developing a process for grant peer review and intramural review, and has asked AAMC to review and endorse that agency as a credible funder of top research. Until that is done, CDC's research credit still will not contribute to its investigators' tenure. The committee expressed great interest in supporting that AAMC validation.

Public Participation in new FACA Advisory Councils at the Coordinating Center Level. Options for public engagement in CDC's work were presented by Dr. Debra Lappin. The literature is deep and wide. Activity such as the Partners' Meeting, the Research Guide, and the HIV meeting on the previous day, produces new collaborators and stakeholders for the agency, and expands understanding of its work.

Ms. Lappin outlined two components of a new platform for expanded public engagement: one, to employ a model to gain external "citizen" input into specific decisions where science and values must be weighed. The second, is to adopt a new framework for FACA advisory committees across the Coordinating Centers, with a significant role for input by external public members.

As the first element, Ms. Lappin noted that Dr. Roger Bernier has developed a new model of interaction that was pilot tested in 2005 through the Public Engagement Pilot Project on Pandemic Influenza (PEPPPI). To rank the goals for a pandemic flu vaccination program, this project asked who first should be vaccinated at the onset of a pandemic, when vaccine supplies are limited. Preliminary data from the University of Nebraska's independent evaluation indicated that: 1) the process affected participant opinions about vaccine distribution; 2) the citizens involved contributed useful information for stakeholder deliberations and 3) the people were satisfied with the

process; and 4) as a result, the stakeholder relationship improved. This provided proof in principle that this process, named the Citizens Process Analysis Collaborative (C-PACE), is both possible and useful to decision makers. It could be a viable model when the Coordinating Center advisory committees consider issues in which science and values converge.

With respect to the development of a new, robust platform for public engagement across the Coordinating Centers, Ms Lappin reviewed input from the IOM and the NRC on the need for an expanded public participatory role with public health. In 1998, the NIH responded by appointing a Council of Public Representatives to examine broad issues of public concern and to give input on research priority setting. It produced significant recommendations and its added dimension was seen as valuable. In 2003, the NAS recommended the routine involvement of NIH councils in priority setting and planning discussions, specifying that the advisory members should be well qualified by scientific or clinical expertise and involved in issues relevant to NIH's mission.

CDC and NIH are Public Health versus Biomedical Research agencies, but have some similarities. Building on NIH's experience and incorporating the C-PACE process, a possible framework for this input, was shared. New champions to Congress could result from an architecture of advisory committees across the Coordinating Centers with a significant component of candidate members from key constituencies, who are nominated from within and without CDC, and who are educated on the complexities of the issues. This would build awareness and transparency, identify new network partners, and perhaps move some dialog from Capitol Hill to Atlanta.

Discussion included endorsement of this approach, with the stipulation that "public" is clearly to be the "informed public," such as ACD members, Mr. Smith and Dr. Lappin. Dr. McIlhane suggested, as possible, use of another word than "public."

Update on Global Disease Detection. An update on Global Disease Detection (GDD) was provided by Dr. Stephen B. Blount, Director, Coordinating Office of Global Health (COGH). CDC's FY06 global disease detection budget is \$33.1 million. The long-term goals are to detect, verify and control natural outbreaks or intentional health threats worldwide, to protect Americans here and abroad, and to share U.S. expertise in disease detection with the world.

Short-term, this work will centrally consolidate outbreak information worldwide, pool expertise into GDD Response Centers, and build capacity for H5 detection/containment in Southeast Asia. In the longer term, it could identify new pathogens, support the GDD network in the WHO regions, and build capacity in WHO and partner countries to respond to virtually any new infectious threat. The country selection criteria for the GDD Centers were outlined. Multiple partners involved in CCGH work include the State Department, USAID, DoD's overseas labs, and corporate entities. The GDD Centers would integrate with WHO and its Global Outbreak Alert and Response Network (GOARN), by collaboratively developing rapid response teams, and assigning senior staff members to Geneva and field staff in WHO regional offices.

Discussion included:

- Mr. Smith suggested GDD contacts: Rick Warren in California, whose network of ~90,000 pastors worldwide use his sermons, and the Vatican Health Council, since many people who die are buried by the local church.
- Dr. Beasley suggested that CDC push gently, through its in-country relationships, for more involvement in the selection of the country's health attachés. The WHO likely can provide entrée to areas resisting CDC entry. Such collaboration is needed to strengthen global systems. Dr. Gerberding suggested that this be on the upcoming meeting agenda, as CDC's global role and positioning is constantly evolving. **ACTION.**
- Dr. Frieden endorsed the increase in GDD programs and complimented CDC's global youth tobacco survey, published in this week's *Lancet*. Such CDC models of disease surveillance and methodology, for both acute and chronic diseases, will advance health among immigrants to the U.S and globally.
- Dr. Benjamin suggested that CDC provide its broad public health expertise as a sort of consultant, to USAID and others working in unfamiliar public health areas, to help them accomplish the goals they are trying to achieve. For example, CDC could screen/interview high level epidemiologist candidates, to ensure that a lesser candidate is not hired only to leave later, frustrating the establishment of a lasting infrastructure.
- Dr. desVignes-Kendrick suggested including the travel industry as a corporate partner. Its relationships with airlines and procedures for collecting passenger information can help in disseminating information. Dr. Gerberding reported that Border Control now requires airlines to provide the passenger manifest to alert health officials if there is an outbreak. The travel industry helped CDC to get that regulation in place.

HIV Initiative: *Domestic Initiative.* Dr. Kevin Fenton, Director, National Center for HIV, STD, and TB Prevention (NCHSTP), reported that ~66% of new infections result from contacts by those unaware that they have HIV. Of those living with HIV, 45% are MSM, 27% are heterosexuals who have high-risk sex, and 22% are IDUs. The changing epidemic demographics produced new strategies to: 1) make HIV testing a routine part of medical care, 2) implement new models for diagnosing HIV infections outside of medical settings, 3) prevent new infections by working with those HIV-positive and their partners, and 4) further decrease perinatal HIV transmission. Components of the \$93 million FY07 HIV testing initiative include testing for persons in health care and non-clinical settings, for incarcerated individuals and IDUs (the latter with SAMHSA), and a joint HHS/DoJ model testing policy initiative.

PEPFAR Report. The *CDC Role in the President's Emergency Program for HIV/AIDS Relied* (PEPFAR) was outlined by Dr. Debbie Birx, Director, Global AIDS Program (GAP), NCHSTP. The PEPFAR goal is to prevent 7 million new infections, support treatment of 2 million HIV-infected people, and support care for >10 million infected or affected by HIV/AIDS in 15 of the world's most HIV-stricken nations. The GAP will

partner with host countries' ministries of health and NGOs, provide technical expertise (epidemiology, medical officers, public health advisors, lab scientists), and collaborate with in-country implementation and management teams. Of the >42 million persons who will be reached, about 400,000 will receive antiretroviral therapy; >2 million women will be treated to prevent maternal transmission to their child (preventing an estimated 47,100 birth infections); 3 million will be treated for HIV, and 9.4 million will receive counseling and testing.

In FY06, GAP will focus on 1) increasing the number of persons reached for prevention, care or treatment services; 2) developing a public health operational research framework; 3) partnership with NIH; 4) building lab capacity and infrastructure in-country and 5) field site development and capacity building (i.e., human in-country capacity).

Discussion included:

- Kenya, Uganda, and Thailand have had convincing HIV decreases.
- There are no data on transmission during incarceration due to the difficulty of doing such research. There are huge variations in prison screening across the U.S., both on entry and in periodic screening. Follow-up in the community with those released is also urgently needed, to prevent a revolving door of infection. Educating the prison (long term) population and the jail (24 hours to a week, short term) population remains a challenge. Dr. Frieden reported New York's scale-up to do rapid tests on ~30,000 of their ~100,000 jail population, most of whom are released within 30 hours. Many are HIV positive, and of those, many were previously diagnosed but had lost care. Consistent linkage to care for them is imperative.
- Mr. Smith suggested highlighting that heterosexual transmission rates are larger than those of MSM and IDUs. Dr. Birx reported that the agencies leverage their core programs worldwide to avoid duplication. All are doing treatment, including DOD and HRSA, but with different models, which allows analysis of the cost effectiveness of each model in each country (e.g., USAID has worked with NGOs, and CDC with health ministries). CDC's focus has been prevention among young adults and those who are HIV positive, reduced risk behavior when on ART, and among commercial sex workers and drug and alcohol abusers. The focus on alcohol prevention messages has increased.
- Dr. Frieden had to demur in response to a negative comment about syringe exchange. Study data show that those programs reduce transmission.
- Dr. Galli commented that those unaware of their infection are usually young and healthy, suggesting that urban emergency departments could identify many presenting for other care. Dr. Fenton agreed; this changing demographic also explained part of the initiative's shift away from traditional health care settings to nonclinical settings (e.g., faith communities, community organizations, HRSA community health centers; and outreach in bars, clubs, and other high risk settings).

Health Information Technology/Biosurveillance/BioSense. An outline of health information technology and the BioSense Program was provided by Ms. Laura Conn, Deputy Director, National Center for Public Health Informatics (NCPHI). BioSenseRT (Real Time) was developed to aggregate data from ED, acute care, and public health every 15 minutes. That can allow early detection, quantification and localization of a possible bioterrorism attack or naturally occurring event, and help to develop a real time national surveillance infrastructure. With that, officials at all levels will be able to not only analyze but visualize events (e.g., geospatially, time series, etc.) and otherwise query the database as needed. The goal is to have 350 participating hospitals by the end of 2006.

Presented survey data showed Americans' increasing acceptance of systems connected to their health benefits – Health Information Technology (HIT) such as electronic health records (EHR). In April 2004, the Office of the National Coordinator for HIT was established to support widespread adoption and measurement/QC of interoperable EHR within ten years, and to ensure the seamless integration of public health and bioterrorism surveillance into care. The industry-accepted standards of the PHIN will be applied in the coding and data transmission at the hospital level. That will provide a foundation for electronic reporting, increase biosurveillance capacity, and identify initial events early for decision maker analysis at all levels.

Discussion included:

- Dr. Frieden expressed some concerns about this project, including the challenge to clean and analyze such a massive amount of data and determine its representativeness, while not knowing what will be done with it. Since response action is generally at the local level, that is where data collection, aggregation, management, and signal follow-up need to be strengthened. Ms. Conn responded that those discussions will continue, and evaluation of these data will be a priority in the coming year. She assured all that the data will not be mined without the support of the local jurisdictions and added that the PHIN was historically a framework for information systems. Since 9/11, it has focused on terrorism; but others focus on outbreak awareness, response, etc.
- Dr. Gerberding pointed out that this is not software, but a way to assemble data. Linking public health and health care would be a big step forward to an aggregated system, a concept that was in development even before 9/11. The difference now is available funding to do it.
- Mr. Smith reported concern in some quarters that DHS could take over this project. Dr. Gerberding said that DHS is responsible for data integration, but linking the data of intelligence, agriculture, defense, and public health is still an imaginary process. So far, CDC has strongly resisted any transfer of raw data, and has focused on primary users of only translated data.

Obesity. CDC's obesity prevention activities were outlined by Dr. Janet Collins, Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). CDC priorities have been to provide national leadership, monitor the obesity epidemic, and build the related science base, capacity, infrastructure and

productive partnerships. CDC commissioned and supported two IOM reports on preventing childhood obesity and on food marketing to children and youth (a \$10 billion a year campaign). An October report will address nutrition standards for food served in schools and how to alter the school environment.

The obesity epidemic has been monitored through the national data of NHANES, the BRFSS, YRBS, and the School Health Policies and Programs Surveillance System (SHPPS). Data from these systems were briefly reviewed.

Significant program updates were provided including the following information:

- Planet Health and CATCH: both school based programs, the former reduced TV viewing by boys and girls and cut obesity in girls. CATCH improved physical activity by 10% and improved the school meal diet. Both are being adopted in states.
- Lifetime Fitness is a program focused on increasing physical activity among older adults. In its first year, adult hospitalizations dropped significantly.
- Methodology and content experts will meet on May 17-18 to discuss the issues related to the causality and methods of estimating the health burden of overweight and obesity.
- The disposition of CDC's current funding was outlined: programs in 28 states address nutrition, physical activity, and obesity prevention in terms of basic prevention and capacity building; 23 states coordinate school health programs, including the tobacco initiative; 40 community programs work to reduce diabetes, overweight, obesity and asthma through physical activities, improved nutrition, and tobacco use cessation.
- In 2005, the 5-A-Day nutrition program was transferred from NCI to CDC.
- One new and important partnership is with the 2500 local YMCAs serving 20 million Americans a year. CDC provides expert advice, evidence-based interventions, dissemination models and leveraged funding to the YMCA "Active America" campaign.

Discussion included:

- Dr. Goodman advised CDC to "be a little less nice" in addressing obesity, to include individual empowerment and responsibility, as was done by MADD to make destructive behavior socially unacceptable. He also advised research and promotion of other fundraising methods than junk food machines.
- Dr. Antronette Yancey urged CDC to explore opportunities to disseminate information through routes other than the obvious partners (e.g., American Heart, or Diabetes Associations), on brief interventions such as brief exercise breaks, healthy snacks, etc. (Dr. Lappin reported for the record that this idea was well-received during the conference call for the March 28 Partners Meeting.) She asked if CDC could include such stipulations to its grantees or, through other federal agencies, the recipients of their funding. Dr. Gerberding responded that this is not an unprecedented model. The federal government

has huge potential power through the USDA's school lunch program and the Department of Education's No Child Left Behind program.

- Dr. Collins reported, based on some evidence that physical activity has a positive relationship to academics, CDC's efforts to reintroduce physical education to schools, working with district offices (often the decision point) and with PTAs. The National Governors' Association also support this. She also reported the IOM report's inclusion of the home setting on its list of factors, in terms of reducing TV time, snacking and other sedentary behavior. The home setting also can engage multiple generations. The VERB project taught a lot about getting families involved, and its data are still being disseminated.
- Mr. Smith raised the liability issue as one component of reduced exercise venues such as playgrounds. He called for liability protection that would still retain litigation rights for malfeasance or gross negligence.

Public Comment. Public comment was solicited, to no response.

Closing Comments. In closing comments, Dr. Gerberding summarized her impressions of the meeting. She expressed her thanks for the breadth and depth of perspective gained from the ACD's advice, and for the meaningful input of the workgroups on Ethics, Research Agenda and Goals. Finally, she personally thanked and gave certificates of appreciation to several members whose ACD tenure ends in June: Dr. Frieden, Dr. Galli, Dr. Makhorn, Dr. Maxwell, Dr. McIlhaney, and Mr. Smith. She hoped they would work with CDC on other committees in the future.

With Dr. Galli's thanks in kind, the meeting then ended at 3:30 p.m.

Attachment #1: Attendance at the February 23, 2006 ACD Meeting

ACD members present:

R. Palmer Beasley, MD
Joel Reed Bender, MD, PhD
Georges C. Benjamin, MD, F.A.C.P.
Mary desVignes-Kendrick, MD, MPH, F.A.A.P.
Thomas Frieden, MD, MPH (via conference call)
Robert L. Galli, MD, Acting Chair
Jay Goodman, PhD
Debra R. Lappin, JD
Sandra K. Mahkorn, MD, MPH, MS
Marilyn A. Maxwell, MD
Joe S. McIlhaney, MD, MPH, MS
W. Shepherd Smith
Antronette K. Yancey, MD, MPH, F.A.C.P.M.

CDC staff:

Ileana Arias	Rima Khabbaz	Jim Murahi
Jay Bernhardt	Murray Kampf	Bradley Perkins
Deborah Bix	Allison Kelly	Alfred Politzer
Steve Blount	Laura Kettel Khan	Jamila Rashid
Mitchell Cohen	Muin Khoury	Matthew Reynolds
Janet Collins	Tamara Kicera	Katie Shebesh
Laura Conn	Donna Knutson	Donald Shriber
José Cordero	Lisa Koonin	Elizabeth Skillen
Cecilia Curry	Crayton Lankford	Dixie Snider
Bob Delaney	Kevin Malone	Bob Spengler
Jan Devier	Ruth Martin	Stephen Thacker
Teresa Durden	Cindi Melanson	Robin Wagner
Kevin Fenton	Toby Merlin	Michelle Wilson
Eve Holland	Tony Moulton	

Attachment 2: CDC Budget

FY 2006 Appropriation

Increases:

- Infectious Disease (AALAC) (+\$3.5M)
- Immunization (+\$30.0M)
- Youth Violence (+\$2.0M)
- Occupational Health and Safety (+\$5.7M)
- Global Disease Detection (+12.0M)
- Strategic National Stockpile (+\$63.6M)

Decreases:

- HIV/AIDS (-\$4.8M)
- VERB (-\$58.0M)
- Block Grant (-\$18.0M)
- PHIN (-\$4.9M)
- Congressional Projects (\$60.5M)
- Terrorism State Grant (\$88.6M)
- BSS (-\$20.0M)

FY 2007 President's Budget

Increases:

- Strategic National Stockpile (+\$69M)
- Botulinum Toxin Research (+3M)
- HIV Testing Initiative (+\$93M)
- Vaccines for Children (+\$49M)
- Pay Raise, UFMS & Rent (+\$18M)

Decreases:

- Block Grant (-\$99M)
- Buildings and Facilities (-\$129M)
- Elimination of CDC Low-Impact Programs (-\$29M)
- West Nile Virus (-\$10M)
- Pandemic Planning One-Time from DOD (-\$77M)
- Anthrax Research Program (-\$14M)
- Administration and Information Technology Savings (-\$38M)

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, February 23, 2006 is accurate and complete to the best of my knowledge.



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

6-1-06

Date